A Situational Analysis on the Status of Women’s and Children’s Rights in Zimbabwe, 2005 - 2010

A Call for Reducing Disparities and Improving Equity
A Situational Analysis on the Status of Women’s and Children’s Rights in Zimbabwe, 2005 - 2010

A Call for Reducing Disparities and Improving Equity
# Table of Contents

Contents .................................................................................................................. iii  
Acknowledgements .................................................................................................. v  
Foreword .................................................................................................................. vii  
Executive summary ................................................................................................. ix  
Lists of figures and tables ....................................................................................... xi  
Acronyms ................................................................................................................ xiii  
Map of Zimbabwe .................................................................................................. xvi  

1. Introduction ................................................................................................. 1  
   1.1. Methodology .......................................................................................... 1  
   1.2 Report outline ......................................................................................... 2  

2. Country context ........................................................................................... 3  
   2.1 Historical overview: Growth with equity ............................................ 3  
      2.1.1 The post-independence period ....................................................... 3  
      2.1.2 The economic liberalisation period .............................................. 4  
      2.1.3 The Crisis period ......................................................................... 5  
   2.2. Zimbabwe Today .................................................................................. 7  
      2.2.1 Political context ........................................................................... 7  
      2.2.2 Economic Growth and Development ......................................... 7  
   2.3 Aid Coordination and Evidence-based Strategic Planning ................. 10  
   2.4 Outlook for the country: Recovery with equity ................................... 12  

3. Care and protection of children and women from violence, abuse and exploitation .......... 13  
   3.1 Social, historical, economic and political context .............................. 13  
   3.2 The protective environment framework ........................................... 16  
      3.2.1 Legal, regulatory and policy frameworks and enforcement ....... 17  
      3.2.2 Government leadership and commitment to protection .......... 18  
      3.2.3 Rights-based customs ................................................................ 20  
      3.2.4 Open discussion and advocacy .................................................... 23  
      3.2.5 Protective essential services ......................................................... 23  
      3.2.6 Capacity of families and communities ....................................... 25  
      3.2.7 Children's and women's life skills, knowledge and participation ... 27  
      3.2.8 Reporting, monitoring and oversight ......................................... 27  
   3.3 Conclusions and recommendations ...................................................... 29  

4. Health and Nutrition of Children and Women .............................................. 31  
   4.1 Historical and socio-economic context .............................................. 31  
   4.2 Legal, regulatory and policy framework ............................................ 32  
   4.3 Challenges within the health system .................................................. 34
## Table of Contents

4.4 HIV and AIDS .......................................................... 35
4.5 Providing a continuum of services in maternal and child health .... 37
  4.5.1 Maternal health .............................................. 37
  4.5.2 Direct causes of child mortality ............................. 38
  4.5.3 Maternal and child nutrition ................................. 41
  4.5.4 Preventing Maternal and Child Undernutrition .......... 47
4.6 Conclusions and recommendations .................................. 49

5. Education .............................................................. 51
  5.1 Background ......................................................... 51
  5.2 Legal, regulatory and policy frameworks ........................ 52
  5.3 Government leadership and commitment ......................... 53
  5.4 Essential Services ................................................ 56
    5.4.1 Teaching Personnel ....................................... 56
    5.4.2 Access to basic and secondary education .............. 58
    5.4.3 Special needs education .................................. 61
    5.4.4 Out of school youth and second chance education .... 61
  5.5 Technical Education .............................................. 61
  5.6 Learning Process ................................................ 63
  5.7 Family and community capacities ................................ 96
    5.7.1 Family financing .......................................... 64
    5.7.2 Parental participation .................................... 66
  5.8 Monitoring progress .............................................. 67
  5.9 Conclusions and recommendations ................................ 67

6. Water, Sanitation and Hygiene (WASH) ................................ 69
  6.1 Background ......................................................... 69
  6.2 Water and Sanitation Coverage and Sector Performance .......... 70
  6.3 Rural services ..................................................... 73
  6.4 Policy and Regulatory Framework ................................ 76
  6.5 Institutional Framework ......................................... 76
  6.6 Financial Situation ................................................ 77
  6.7 Equity .............................................................. 78
  6.8 Conclusion and Recommendations ................................ 80

7. Conclusion and recommendations ..................................... 83

Bibliography ............................................................ 85

Annex I Livelihoods and coping strategies of women and children in rural areas .................. 99
This Situational Analysis (SitAn) of children and women in Zimbabwe is the combined effort of Government Ministries, UN agencies, and civil society, all of whom contributed throughout its development. Sincere appreciation is extended to the many people who provided valuable insights for this report, particularly the staff of the University of Zimbabwe, Centre for Applied Social Sciences.
As the world turns to 2015 when all countries will be evaluated against their progress on the Millennium Development Goals, it is increasingly clear that women and children are central to the achievement of the majority of these goals. Furthermore, it is clear that some of the goals on which Zimbabwe has made least progress, are goals that involve women and children very directly, such as MDGs 4 and 5, on child survival and maternal survival respectively. As the leader of the cluster responsible for the social sectors, it is increasingly clear that the success of the Inclusive Government will be measured, not just by improvement in the political and economic situation, but by how successful we have been in helping women and children, especially the poorest and most vulnerable women and children, to realize their rights.

This report, A Situational Analysis on the Status of Women and Children's Rights in Zimbabwe, provides a comprehensive overview encompassing the latest data in all the critical social sectors, including health, education, water and sanitation, and child and social protection. The report goes beyond the national averages to uncover some of the trends in inequity and vulnerability by geographical region, by religion, and by levels of poverty. In addition, beyond describing the problem, it also illustrates some examples of successful programmes that are addressing these problems and, where available, provides information from evaluations or exercises on lesson learned and makes important recommendations.

What emerges is a story of challenges and a story of opportunity. There is no doubt that after much progress in the 1980s, the status of women and children has deteriorated over the past two decades, particularly in the past 10 years. Maternal mortality has more than doubled since 1990. Every day, 100 Zimbabwean children under the age of 5 and eight Zimbabwean mothers are dying, mostly preventable deaths. More than one third of children face a permanent limitation on their life potential due to chronic malnutrition or stunting. And the integrity of the education system is under threat leaving many children and young people without viable learning or employment options. Finally, it is clear that, as the economic situation has declined, the poorest and most vulnerable are increasingly bearing a disproportionate proportion of the disease burden, of deprivation and of rights violations.

And yet the report also indicates that Zimbabwe has achieved success before and, with the right investment choices, policies and priorities, Zimbabwe can once again be at the forefront of social progress and of advancing the cause of women and children's rights. Indeed, the recent progress in many of these areas is very encouraging. I urge all decision makers across the diplomatic and donor community, civil society, UN agencies, private sector and my own colleagues in Government to, not only read this report carefully, but to consider it as a blueprint for collective action to support the most pressing development priority of our times, the women and children of Zimbabwe.

Thokozani Khupe
Deputy Prime Minister of the Republic of Zimbabwe
Executive Summary

Through its focus on the social sectors in the 1980s, post-independence Zimbabwe made major gains in upholding children and women's rights and reducing disparities. The 1990s saw an era of structural adjustment programmes with associated austerity measures. The problems caused by these changes in policy and budget allocations were compounded by the onset of the HIV epidemic. Finally, in the past decade, the dramatic economic contraction and political problems have resulted in further deterioration in the status of women and children.

The focus of this document is the period from 2005 through 2010 and is intended to serve as an assessment of the status of women and children's rights. The document will also inform the priorities of the new UNICEF country programme to be developed for the period 2012 to 2015 within the framework of the Zimbabwe United Nations Development Assistance Framework (ZUNDAF). Much of the data are derived from the Multiple Indicator Monitoring Survey (MIMS) conducted by Zimstats (formerly Central Statistics Office) with the support of UNICEF in 2009. In the absence of a final national development framework, the analysis has taken as a reference point the Short Term Emergency Recovery Programme (STERP), the Government Works Programme and the draft Medium-Term Plan (MTP).

The analysis has been completed during a critical period of transition in the country. The Global Political Agreement was signed by the three political parties in September 2008. The Inclusive Government, inaugurated in February 2009, managed to control the massive hyper-inflation, stabilize the economy and restore some of the basic social services, all within 18 months. In addition, the major cholera and measles epidemics that affected the country in 2008-2009, and 2009-2010, highlight so dramatically the deterioration on and underlying vulnerability of the systems and infrastructure of all the social sectors, have also largely been brought under control. Food security is also steadily improving and the proportion of the population dependent on food aid decreasing. Due to a combination of mortality and real change in incidence as a consequence of behavioural change, HIV prevalence is declining. However, the maturity and magnitude of the HIV epidemic, the massive rate of orphaning that has occurred as a consequence, and the inter-related high household poverty levels have exacerbated vulnerabilities and are leading to stark disparities across a range of indicators. Simultaneously, there is a risk that a cycle of violence may develop that runs the full spectrum from rampant corporal punishment through to sexual abuse, gender-based violence and politically-motivated violence.

Overall, the period from 2005 to 2010 has seen a further deterioration in the critical social sectors. In fact, during 2008 and 2009, many social sectors had all but collapsed. The education system, once arguably the best on the continent, has begun to falter badly. Although enrolment rates have remained high, examination pass rates and other indicators of quality are plummeting. In the absence of significant central government financing, a complex system of fees, levies and 'incentives' has evolved that further disadvantages the poorest. A full 50 per cent of students no longer continue their schooling beyond grade seven. The students from the poorest quintiles make the transition even less frequently. In the absence of opportunities for vocational training, formal employment or to be integrated back into the educational system, this group of children and young people remains highly vulnerable. Teachers' salaries do not represent a living wage and combined with the absence of learning and teaching materials and declining standards have led to a crisis of standards and motivation in the teaching profession.

The once strong primary health care system has also faltered badly. The maternal mortality ratio has more than doubled since 1990, the baseline year for the Millennium Development Goals and under five mortality has increased by more than 20 per cent. User fees are limiting access to basic health services, particularly for curative interventions such as emergency obstetric care, and for women in rural areas or in the poorest quintiles. Newborn disorders have been recognized as the major cause of under five mortality and are intrinsically linked to maternal health. The major gains made in ensuring access for HIV positive adults to anti-retroviral therapy have not yet been replicated for children, particularly within the first two years of life. While severe acute malnutrition remains stable at a prevalence of less than 3 per cent, chronic under-nutrition or stunting, a reflection of poor caring practices, poor sanitation and poor dietary diversity, now affects more than one-third of children. More than 40 per cent of rural Zimbabweans now practice open
Executive Summary

defecation as their only form of sanitation and the link between poor sanitation and stunting is attracting increasing research interest. Finally, the health system continues to face historical challenges of paying and motivating its workforce in a sustainable manner and newer challenges such as the increasing proportion of the population that belong to religious groups that do not automatically adopt recommended health interventions.

Underpinning all of these areas, the protective environment for women and children is cracking. Government social protection mechanisms that functioned well previously, such as the Social Development Fund and child supplementary feeding programmes, have fallen away. The social welfare and justice for children sectors are also limited by a loss of human and administrative capacity. As the coping strategies of families and communities have become increasingly taxed, children have become more and more vulnerable to violence, exploitation and abuse in schools, communities, across borders and within their own homes with little recourse to justice services. The legislative and policy framework for children’s protection requires revision in line with emerging priorities, for example, on children’s criminal age of responsibility. International treaties such as the Convention on the Rights of the Child are not yet domesticated and thus largely unable to be enforced in legal decision-making.

And yet despite these very serious challenges, there is much room for optimism. First, the Inclusive Government of Zimbabwe is placing a high priority on stimulating economic growth with equity and recognizes the central role of the social sectors in the rebuilding of the country. The transition period is providing an opportunity for making important policy decisions and pro-poor advances, such as removing or reducing financial barriers to accessing health, water and other social services and improving access to others by revitalising programmes that ensure access for the most vulnerable, such as the Basic Education Assistance Module (BEAM). Government is also initiating pre-trial diversion programmes for minors, child-friendly courts and expanding programmes targeting survivors of abuse. Importantly it is also making significant commitments from its own limited resources. Every effort must be made to support the successful implementation of such policy reform during this transitional period. As domestic revenues improve, the social sectors should continue to be prioritised. Finally, as new programmes are developed, such as national cash transfer schemes for labour constrained households, robust operational research is needed to ensure effective targeting, links to social sector outcomes and ultimately reductions in poverty.

Second, despite the lack of external resources flowing directly to government and the massive loss of capacity, the basic human and physical infrastructure still exists to some extent in most sectors. In addition, transitional financing mechanisms in education, health, water and social protection are providing innovative ways to support the revitalisation of these sectors. The international donor community should continue to support mechanisms, such as the Education Transition Fund, which are providing a critical bridge between humanitarian activities and the rebuilding of national capacity in critical sectors.

Third, the people of Zimbabwe are both highly literate and also remember well what it was like to have good services; they will continue to demand their entitlements from the State. Programmes that increase awareness among women, children and young people of their entitlements and also stimulate and support positive behaviours at individual and community level should be expanded. These include early and exclusive breastfeeding, hand-washing with soap, reduction of high risk sexual encounters and the strong involvement of communities in governance, accountability and maintenance of social services.

Finally, and most importantly, the Inclusive Government, through the constitutional reform process, the establishment of commissions including a Human Rights Commission, is clearly making good faith efforts to improve governance and allow a conducive environment for rebuilding the nation; most notably, by involving children themselves in the constitution-making process. The United Nations, civil society organisations and international donor community must support all of these efforts. Ultimately it is the success or failure of these efforts that will determine the future for the women and children of Zimbabwe.
List of figures and tables

List of figures
- Figure 1: Map of Zimbabwe ............................................. xvi
- Figure 2: Human Development Index (HDI) and Gini Coefficients from 1975-2005 .......... 3
- Figure 3: Zimbabwe GDP Growth 1994-2007 .......................................................... 5
- Figure 4: Zimbabwe CPI inflation, annual average, 2001-2007 .................................. 5
- Figure 5: Percentage of households below Food Poverty Line by Province 1995 and 2003 .................................................. 6
- Figure 6: Budgetary allocations to Child Service Ministries 2005-2009......................... 9
- Figure 7: Access to services by wealth quintile ......................................................... 10
- Figure 8: Donor Aid to Zimbabwe, 2006-2008 .......................................................... 10
- Figure 9: National structure of aid coordination ....................................................... 11
- Figure 10: Increase in Orphan Numbers in Zimbabwe between 1995 and 2005 orphans in Zimbabwe .................................................. 14
- Figure 11: Epidemic curves showing population numbers for HIV prevalence and AIDS orphans in Zimbabwe .................................................. 14
- Figure 12: Reported abuse against boys and girls by type ........................................ 16
- Figure 13: Targeting for future Programmes of Support ........................................ 19
- Figure 14: Coordination of OVC response through the Programme of Support ............. 21
- Figure 15: Percentage of women age 15-49 who have experienced different forms of violence in Zimbabwe .................................................. 22
- Figure 16: Justice for Children System ................................................................... 25
- Figure 17: Infant and Under 5 Mortality Rates 1990 to 2008 and MDG Targets - Zimbabwe ........................................................................ 32
- Figure 18: Health coverage gap index in Zimbabwe 1994 to 2005 ............................ 32
- Figure 19: Role of religion and access to health services ........................................ 33
- Figure 20: Trends in Availability of Selected Essential Drugs in Health Facilities, Zimbabwe .................................................. 35
- Figure 21: Trends in adult HIV prevalence 1981 to 2007 ........................................... 36
- Figure 22: Maternal Mortality (per 100,000 live births) adjusted figure 1990-2010 ... 37
- Figure 23: Skilled birth attendance by wealth quintile in Zimbabwe, 1994 to 2009 .... 38
- Figure 24: Causes of Under-5 Mortality in Zimbabwe ................................................ 39
- Figure 25: Causes of Neonatal Deaths ................................................................... 39
- Figure 26: Prevalence of Stunting in children aged 6 - 59 months, by district .......... 41
- Figure 27: Rates of moderate stunting by wealth quintile and year of data collection ... 42
- Figure 28: Mean Z-Score for stunting, wasting, and underweight, by age in months .... 43
- Figure 29: Seasonal food security timeline ............................................................... 44
- Figure 30: Percentage of children consuming specified foods, by age grouping ...... 45
- Figure 31: Attendance rates for primary and secondary school, by quintile ............... 52
- Figure 32: Breakdown of education budget in 2009 national budget ......................... 54
- Figure 33: Education Revenue by Province 2009 ..................................................... 55
- Figure 34: Requirements for Teacher Qualifications ................................................ 56
- Figure 35: Grade enrolment as a percentage of total enrolment in 2009 .................... 58
- Figure 36: Ordinary and advanced level pass rates - 2005-2009 .............................. 63
- Figure 37: Trends in Water Supply and Sanitation Coverage Using Commonly Accepted Estimates .................................................. 71
- Figure 38: Trends in Zimbabwe Water Supply Coverage 1990 to 2010 Using JMP Estimates .................................................. 71
List of figures and tables

- Figure 39 and 40: Urban and Rural Trends in Water Supply by Population 1990-2010 ................................................................. 71
- Figure 41: Sanitation Coverage Trends, 1990 - 2010 ................................................................. 72
- Figure 42: Levels of open defecation in SADC region ......................................................... 75
- Figure 43: Zimbabwe Ministerial Coordination Structure for WASH ........................................... 77
- Figure 44: Sanitation Coverage Trends by Wealth Quintiles, Zimbabwe 1990 - 2010 ........ 79
- Figure 45: Percent children 0-59 months of age residing in households using improved water and sanitation facilities ............................................. 79

List of figures (Annex 1)
- Figure 1: Education levels attained by head of household .................................................. 101
- Figure 2: Highest level of education attained by any household member .......................... 102
- Figure 3: Marital status of household heads ................................................................. 102
- Figure 4: Percentage contribution of income sources to total household income ............ 104
- Figure 5: Coping strategies by gender of household head .................................................. 105

List of tables
- Table 1: Effects of Changes in revenue and expenditure on the budget deficit ......................... 4
- Table 2: Ratio of Children to Social Workers in Selected Countries in Southern Africa .................. 24
- Table 3: Addressing malnutrition in Zimbabwe ............................................................... 46
- Table 4: School fees and levies ....................................................................................... 66
- Table 5: Milestones of Water and Sanitation Development in Zimbabwe ......................... 70
- Table 6: Estimated annual investment requirements for water to reach the MDGs .............. 82
- Table 7: Estimated annual capital development requirement for sanitation to reach the MDGs ........................................................................ 82

List of tables (Annex 1)
- Table 1: Mean, Minimum and Maximum distances to social and physical amenities .................................................. 100
- Table 2: Socio-economic characteristics of household heads ........................................... 100
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACRWC</td>
<td>African Charter on the Rights and Welfare of the Child</td>
</tr>
<tr>
<td>AFDB</td>
<td>African Development Bank</td>
</tr>
<tr>
<td>AIDS</td>
<td>Acquired Immuno Deficiency Syndrome</td>
</tr>
<tr>
<td>AMTO</td>
<td>Assisted Medical Treatment Orders</td>
</tr>
<tr>
<td>ART</td>
<td>Antiretroviral Therapy</td>
</tr>
<tr>
<td>ARV</td>
<td>Antiretroviral</td>
</tr>
<tr>
<td>AU</td>
<td>African Union</td>
</tr>
<tr>
<td>BEAM</td>
<td>Basic Education Assistance Module</td>
</tr>
<tr>
<td>BRTI</td>
<td>Biomedical Research Training Institute</td>
</tr>
<tr>
<td>CAP</td>
<td>Consolidated Appeal Process</td>
</tr>
<tr>
<td>CBM</td>
<td>Community Based Management</td>
</tr>
<tr>
<td>CCORE</td>
<td>Collaborative Centre for Operational Research and Evaluation</td>
</tr>
<tr>
<td>CD4</td>
<td>A measure of the number of helper T-cells per cubic millimetre of blood</td>
</tr>
<tr>
<td>CDC</td>
<td>Centers for Disease Control and Prevention</td>
</tr>
<tr>
<td>CEDAW</td>
<td>Convention on the Elimination of all forms of Discrimination Against Women</td>
</tr>
<tr>
<td>CMAM</td>
<td>Community Management of Acute Malnutrition</td>
</tr>
<tr>
<td>COPAC</td>
<td>Constitutional Parliamentary Select Committee</td>
</tr>
<tr>
<td>CRC</td>
<td>Convention on the Rights of the Child</td>
</tr>
<tr>
<td>CSC</td>
<td>Community Selection Committees</td>
</tr>
<tr>
<td>CSO</td>
<td>Civil Society Organisation</td>
</tr>
<tr>
<td>CWC</td>
<td>Child Welfare Council</td>
</tr>
<tr>
<td>CWGH</td>
<td>Community Working Group on Health</td>
</tr>
<tr>
<td>DDF</td>
<td>District Development Fund</td>
</tr>
<tr>
<td>DHS</td>
<td>Demographic and Health Survey</td>
</tr>
<tr>
<td>DSS</td>
<td>Department of Social Services (MoLSS)</td>
</tr>
<tr>
<td>ECD</td>
<td>Early Childhood Development</td>
</tr>
<tr>
<td>ECEC</td>
<td>Early Childhood Education and Care</td>
</tr>
<tr>
<td>EFA</td>
<td>Education for All</td>
</tr>
<tr>
<td>EMA</td>
<td>Environmental Management Agency</td>
</tr>
<tr>
<td>EPI</td>
<td>Expanded Programme of Immunisation</td>
</tr>
<tr>
<td>ERRR</td>
<td>Emergency Rehabilitation and Risk Reduction</td>
</tr>
<tr>
<td>ESAP</td>
<td>Economic Structural Adjustment Programme</td>
</tr>
<tr>
<td>FAO</td>
<td>Food and Agriculture Organisation</td>
</tr>
<tr>
<td>FBO</td>
<td>Faith Based Organisation</td>
</tr>
<tr>
<td>FNC</td>
<td>Food and Nutrition Council</td>
</tr>
<tr>
<td>FNSP</td>
<td>Food and Nutrition Security Policy</td>
</tr>
<tr>
<td>FPL</td>
<td>Food Poverty Line</td>
</tr>
<tr>
<td>GBV</td>
<td>Gender Based Violence</td>
</tr>
<tr>
<td>GDP</td>
<td>Gross Domestic Product</td>
</tr>
<tr>
<td>GDF</td>
<td>Government Development Forum</td>
</tr>
<tr>
<td>GNU</td>
<td>Government of National Unity</td>
</tr>
<tr>
<td>GoZ</td>
<td>Government of Zimbabwe</td>
</tr>
<tr>
<td>GPA</td>
<td>Global Political Agreement</td>
</tr>
<tr>
<td>HDI</td>
<td>Human Development Index</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immuno Virus</td>
</tr>
<tr>
<td>IASC</td>
<td>Inter-agency Standing Committee</td>
</tr>
<tr>
<td>ICPD</td>
<td>International Conference on Population and Development</td>
</tr>
<tr>
<td>IDD</td>
<td>Iodine Deficiency Disorder</td>
</tr>
<tr>
<td>IFNFS</td>
<td>Institute of Food, Nutrition, and Family Sciences</td>
</tr>
<tr>
<td>IGME</td>
<td>Inter-agency Group for Child Mortality Estimation</td>
</tr>
<tr>
<td>ILO</td>
<td>International Labour Organisation</td>
</tr>
</tbody>
</table>
## Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>IMNCI</td>
<td>Integrated Management of Newborn and Child Illness</td>
</tr>
<tr>
<td>IPT</td>
<td>Intermittent Presumptive Treatment</td>
</tr>
<tr>
<td>IRWSP</td>
<td>Integrated Rural Water Supply Project</td>
</tr>
<tr>
<td>ITN</td>
<td>Insecticide Treated Net</td>
</tr>
<tr>
<td>IYCF</td>
<td>Infant and Young Child Feeding</td>
</tr>
<tr>
<td>JMP</td>
<td>Joint Monitoring Programme</td>
</tr>
<tr>
<td>MDC</td>
<td>Movement for Democratic Change</td>
</tr>
<tr>
<td>MDC-M</td>
<td>Movement for Democratic Change - Mutambara faction</td>
</tr>
<tr>
<td>MDC-T</td>
<td>Movement for Democratic Change - Tsvangirai faction</td>
</tr>
<tr>
<td>MDGs</td>
<td>Millennium Development Goals</td>
</tr>
<tr>
<td>MER</td>
<td>More Efficacious (PMTCT Prophylaxis) Regimen</td>
</tr>
<tr>
<td>MDTF</td>
<td>Multi-donor Trust Fund</td>
</tr>
<tr>
<td>MILGRUD</td>
<td>Ministry of Local Government, Rural and Urban Development</td>
</tr>
<tr>
<td>MIMS</td>
<td>Multiple Indicator Monitoring Survey</td>
</tr>
<tr>
<td>MMR</td>
<td>Maternal Mortality Ratio</td>
</tr>
<tr>
<td>MNCH</td>
<td>Maternal, Neonatal and Child Health</td>
</tr>
<tr>
<td>MoA</td>
<td>Ministry of Agriculture</td>
</tr>
<tr>
<td>MoCPA</td>
<td>Ministry of Constitutional and Parliamentary Affairs</td>
</tr>
<tr>
<td>MoESAC</td>
<td>Ministry of Education, Sport, Arts and Culture</td>
</tr>
<tr>
<td>MoEn</td>
<td>Ministry of Environment and Natural Resources Management</td>
</tr>
<tr>
<td>MoF</td>
<td>Ministry of Finance</td>
</tr>
<tr>
<td>MoHA</td>
<td>Ministry of Home Affairs</td>
</tr>
<tr>
<td>MoHCW</td>
<td>Ministry of Health and Child Welfare</td>
</tr>
<tr>
<td>MoHTE</td>
<td>Minstry of Higher and Tertiary Education</td>
</tr>
<tr>
<td>MoLSS</td>
<td>Ministry of Labour and Social Services</td>
</tr>
<tr>
<td>MoTCID</td>
<td>Ministry of Transport, Communications and Infrastructure Development</td>
</tr>
<tr>
<td>MoWAGCD</td>
<td>Ministry of Women Affairs, Gender and Community Development</td>
</tr>
<tr>
<td>MoWRDM</td>
<td>Ministry of Water Resources Development and Management</td>
</tr>
<tr>
<td>MRCZ</td>
<td>Medical Research Council of Zimbabwe</td>
</tr>
<tr>
<td>MT</td>
<td>Metric Tonnes</td>
</tr>
<tr>
<td>MTP</td>
<td>Medium Term Plan</td>
</tr>
<tr>
<td>NAC</td>
<td>National AIDS Council</td>
</tr>
<tr>
<td>NAC</td>
<td>National Action Committee (for WASH)</td>
</tr>
<tr>
<td>NAP</td>
<td>National Action Plan (for Orphans and Vulnerable Children)</td>
</tr>
<tr>
<td>NCU</td>
<td>National Coordinating Unit (for WASH)</td>
</tr>
<tr>
<td>NEAB</td>
<td>National Education Advisory Board</td>
</tr>
<tr>
<td>NECD</td>
<td>National Early Childhood Development</td>
</tr>
<tr>
<td>NER</td>
<td>Net enrolment ratios</td>
</tr>
<tr>
<td>NERP</td>
<td>National Economic Revival Programme</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-Governmental Organisation</td>
</tr>
<tr>
<td>NMWP</td>
<td>National Master Water Plan for Rural Water Supply and Sanitation</td>
</tr>
<tr>
<td>NND</td>
<td>National Nutrition Department</td>
</tr>
<tr>
<td>NSDS</td>
<td>National Strategy for Development of Statistics</td>
</tr>
<tr>
<td>NSS</td>
<td>National Statistical System</td>
</tr>
<tr>
<td>ORT</td>
<td>Oral Rehydration Therapy</td>
</tr>
<tr>
<td>OVC</td>
<td>Orphans and Vulnerable Children</td>
</tr>
<tr>
<td>PASS</td>
<td>Poverty Assessment Study Survey</td>
</tr>
<tr>
<td>PCN</td>
<td>Primary Care Nurse</td>
</tr>
<tr>
<td>PHC</td>
<td>Primary Health Care</td>
</tr>
<tr>
<td>PHHE</td>
<td>Participatory Health and Hygiene Education</td>
</tr>
<tr>
<td>PMTCT</td>
<td>Prevention of Mother to Child Transmission</td>
</tr>
<tr>
<td>Acronym</td>
<td>Description</td>
</tr>
<tr>
<td>----------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>PoS</td>
<td>Programme of Support to the National Action Plan for Orphans and Vulnerable Children</td>
</tr>
<tr>
<td>PPP</td>
<td>Purchasing Power Parity</td>
</tr>
<tr>
<td>RDC</td>
<td>Rural District Council</td>
</tr>
<tr>
<td>RN</td>
<td>Registered Nurse</td>
</tr>
<tr>
<td>RSH</td>
<td>Rural Sanitation and Hygiene</td>
</tr>
<tr>
<td>RWS</td>
<td>Rural Water Supply</td>
</tr>
<tr>
<td>SACMEQ</td>
<td>Southern African Measures for Educational Quality</td>
</tr>
<tr>
<td>SADC</td>
<td>Southern African Development Community</td>
</tr>
<tr>
<td>SAG</td>
<td>Strategic Advisory Group</td>
</tr>
<tr>
<td>SDC</td>
<td>School Development Committee</td>
</tr>
<tr>
<td>SOWC</td>
<td>State of the World's Children</td>
</tr>
<tr>
<td>STERP</td>
<td>Short-Term Emergency Recovery Programme</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually Transmitted Infection</td>
</tr>
<tr>
<td>TARSC</td>
<td>Training and Research Support Centre</td>
</tr>
<tr>
<td>TCPL</td>
<td>Total Consumption Poverty Line</td>
</tr>
<tr>
<td>RUTF</td>
<td>Ready-to-use Therapeutic Food</td>
</tr>
<tr>
<td>UDHR</td>
<td>Universal Declaration of Human Rights</td>
</tr>
<tr>
<td>UHS</td>
<td>Urban Hygiene and Sanitation</td>
</tr>
<tr>
<td>UNCTAD</td>
<td>United Nations Conference on Trade and Development</td>
</tr>
<tr>
<td>UNDP</td>
<td>United Nations Development Programme</td>
</tr>
<tr>
<td>UNFPA</td>
<td>United Nations Population Fund</td>
</tr>
<tr>
<td>UNICEF</td>
<td>United Nations Children's Fund</td>
</tr>
<tr>
<td>USD</td>
<td>United States Dollars</td>
</tr>
<tr>
<td>UWS</td>
<td>Urban Water Supply</td>
</tr>
<tr>
<td>VAM</td>
<td>Vulnerability Analysis and Mapping</td>
</tr>
<tr>
<td>VFC</td>
<td>Victim Friendly Court</td>
</tr>
<tr>
<td>VFU</td>
<td>Victim Friendly Unit</td>
</tr>
<tr>
<td>VHW</td>
<td>Village Health Worker</td>
</tr>
<tr>
<td>VIP</td>
<td>Ventilated Improved Pit latrines</td>
</tr>
<tr>
<td>VMSP</td>
<td>Vital Medicines Support Programme</td>
</tr>
<tr>
<td>WASH</td>
<td>Water and Sanitation and Hygiene</td>
</tr>
<tr>
<td>WFFC</td>
<td>World Fit For Children</td>
</tr>
<tr>
<td>WFP</td>
<td>World Food Programme</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
<tr>
<td>WSS</td>
<td>Water Supply and Sanitation</td>
</tr>
<tr>
<td>ZANU-PF</td>
<td>Zimbabwe African National Union - Patriotic Front</td>
</tr>
<tr>
<td>ZCO</td>
<td>Zimbabwe Country Office</td>
</tr>
<tr>
<td>ZESA</td>
<td>Zimbabwe Electricity Supply Authority</td>
</tr>
<tr>
<td>ZIMCORD</td>
<td>International Conference on Reconstruction and Development</td>
</tr>
<tr>
<td>ZIMPREST</td>
<td>Zimbabwe Programme of Economic and Social Transformation</td>
</tr>
<tr>
<td>ZIMSEC</td>
<td>Zimbabwe Schools Examination Council</td>
</tr>
<tr>
<td>ZIMSTAT</td>
<td>Zimbabwe Statistics Agency</td>
</tr>
<tr>
<td>ZimVAC</td>
<td>Zimbabwe Vulnerability Assessment Committee</td>
</tr>
<tr>
<td>ZINWA</td>
<td>Zimbabwe National Water Authority</td>
</tr>
<tr>
<td>ZMERP</td>
<td>Zimbabwe Millennium Economic Recovery Plan</td>
</tr>
<tr>
<td>ZNASP</td>
<td>Zimbabwe National HIV and AIDS Strategic Plan</td>
</tr>
<tr>
<td>ZRP</td>
<td>Zimbabwe Republic Police</td>
</tr>
<tr>
<td>ZUNDAF</td>
<td>Zimbabwe United Nations Development Assistance Framework</td>
</tr>
<tr>
<td>ZWLA</td>
<td>Zimbabwe Women Lawyers Association</td>
</tr>
</tbody>
</table>
Figure 1: Map of Zimbabwe
Introduction

‘The future of Africa lies with the wellbeing of its children and youth… Today’s investment in children is tomorrow’s peace, stability, security, democracy and sustainable development’.

The situation of children and women in Zimbabwe is determined by the social, economic and political environment, together with the existing institutional arrangements, which provide for or deny their rights and welfare. During the past decade Zimbabwe experienced erratic rainfall, economic collapse, political instability, and a near-collapse of public services. The welfare of children and women suffered as households were pushed into poverty. More recently, economic and political reforms have stabilized the economy and resulted in a renewed commitment to achieve the Millennium Development Goals (MDGs) by 2015.

The purpose of the Situation Analysis of Children and Women in Zimbabwe is to consider the situation facing children and women in 2010 and analyse how this affects the realisation of their rights. This Situation Analysis takes into account statistical trends, policies and budgets relating to the rights and welfare of girls, boys and women. While the report provides a brief review of the historical background, its primary focus is an analysis of the present situation with a view to assessing the future prospects for supporting children and women’s rights.

1.1. Methodology

A human rights based approach has guided the analysis undertaken in this report, encompassing social, economic, political and civil rights. The Situation Analysis has been developed through a participatory and inclusive process with Government, civil society, multilateral and bilateral partners, and children themselves.

An extensive literature review was undertaken, as the purpose was to use and synthesise existing information, rather than generate new primary data. The main sources for primary survey data were the national Demographic and Health Surveys (DHS) and the 2009 Multiple Indicator Monitoring Survey (MIMS). In addition to national reports, smaller, sub-national studies have been reviewed and conclusions carefully interpreted when applied to the national context. The Centre for Applied Social Sciences provided valuable insights on the situation of women and children living in rural areas.
Introduction

1.2 Report outline

The Situation Analysis opens with a description of the Zimbabwe context, with a particular focus on events that have taken place over the last five years since the last Situation Analysis was prepared. The Country Context, in Chapter Two, considers the macroeconomic, political and development environment which serves as the foundation for the sectoral chapters.

Chapter Three considers the Care and Protection of Children and Women, in particular the different vulnerabilities they face in the form of violence, abuse, exploitation and discrimination.

Chapter Four reviews the Health of Women and Children from a broad perspective that includes HIV, maternal health, child survival, and nutrition.

Chapter Five focuses on Education, including access to education, the learning process and the quality of education provided in schools. In addition, children with special needs and out of school children are also considered.

Chapter Six addresses the situation of safe Water, Sanitation and Hygiene.

Chapter Seven draws the Conclusions from the analysis and closes with Recommendations for policy making and programme development.
2.1 Historical overview: Growth with equity


2.1.1 1980-1990: the post-independence period

Upon its independence in 1980, Zimbabwe inherited a hybrid economy with a combination of a diversified modern economy and a rural subsistence farming sector which underpinned a highly unequal social-economic and political system. In 1981, the Government of Zimbabwe set out a grand plan - "Growth with Equity: An Economic Policy Statement" which aimed to build a socialist and egalitarian society. This period was characterized by impressive economic growth and major social programmes with the objective of reducing economic and social inequities, including food subsidies, expanded education, health and water investments and the setting of minimum wages. These policies not only led to major improvements across social indicators but also a sharp decline in disparities. The Human Development Index, a composite index capturing a society's living standards as well as state of health and education, showed continued progress during this period, while the rest of Africa experienced the so-called "lost decade". The Gini coefficient, a common measure of income inequality dropped significantly during this period from 0.623 in 1969 to 0.568 in 1990. Figure 2: HDI and Gini co-efficient from 1975-2005 maps these changes over time.

Figure 2: Human Development Index (HDI) and Gini Coefficients in Zimbabwe, 1975-2005


Footnotes:
3 Sanders D, 1990, p5-22.
Country Context

However, private sector and foreign investment in productive capacity was limited. These problems were compounded by unfavourable rainfall patterns and a high budget deficit resulting from unsustainable public sector expenditure. By the mid 1980s, economic growth started to falter and the country decided to resort to the structural adjustment reforms.4

2.1.2 1990-1997: the economic liberalisation period

In 1991, the Economic Structural Adjustment Programme (ESAP) ushered in a wave of initiatives including trade liberalization, budget deficit reduction, deregulation of prices, wages, transport and investment, and commercialization and efficiency improvement of parastatals. However, the anticipated positive effects of the reforms were not realized. During this period, the HDI showed a marked decline. The budget deficit remained high and Government borrowing pushed up interest rates, discouraging investment and growth. Inflation rose to double-digits ranging between 20-25 per cent per annum. Due to these factors and recurrent drought, real GDP growth fell to around 1.5 per cent per annum.5

The effects of these processes on the budget deficit are presented in Table 1 below.

During this period, large numbers of workers were retrenched as industries shut down and public spending was curtailed. One study showed that the unemployment rate rose from 32.2 per cent to 44 per cent in three years. Even those who managed to keep their jobs saw their wages decline sharply. Meanwhile, the liberalization of prices and the elimination of food subsidies resulted in severe hardship for the masses. The introduction of user fees in social sectors to recover costs resulted in a seven-fold increase in the cost of healthcare, for example, and rendered these services inaccessible by the poor and unemployed.7 The Social Development Adjustment Fund which aimed to mitigate the social impact of ESAP was poorly designed, implemented and funded and therefore proved to be ineffective.8 The economic situation was further worsened by an unprecedented drought in 1992-1993. The HIV epidemic, which reached its peak during this period with a prevalence rate close to 30 per cent among 15-49 year olds, also started to take its toll on the economy in terms of reduced productivity and heightened medical costs.

<table>
<thead>
<tr>
<th>Year</th>
<th>Change of Revenue</th>
<th>Change in Expenditure</th>
<th>Change in Budget Deficit</th>
</tr>
</thead>
<tbody>
<tr>
<td>1980/81 to 1984/85</td>
<td>1 122</td>
<td>-1 815</td>
<td>-693</td>
</tr>
<tr>
<td>1985/86 to 1989/90</td>
<td>1 040</td>
<td>-1 009</td>
<td>31</td>
</tr>
<tr>
<td>1993/94 to 1997/98</td>
<td>1 166</td>
<td>1 997</td>
<td>-831</td>
</tr>
</tbody>
</table>

Table 1: Effects of Changes in revenue and Expenditure on the Budget Deficit
Source: Ndlela, D in Human Security in Zimbabwe

Note: The sign on expenditure has been reversed, to show its impact on the deficit.

FOOTNOTES

4 UNDP, 2008.
5 UNDP, 2008.
By 1997, the economic crisis had deepened such that the government replaced ESAP with the Zimbabwe Programme of Economic and Social Transformation (ZIMPREST). ZIMPREST placed great emphasis on national development, envisaging a comprehensive restructuring of Government to achieve efficient delivery of key services and to facilitate economic empowerment, private sector development and job creation. Unfortunately, it was not able to arrest the economic difficulties facing Zimbabwe, such as the rapid depreciation of the Zimbabwe dollar and the increasing rate of inflation, intensified balance of payment pressures and eroded business confidence.

The pursuit of economic liberalization, without paying adequate attention to the deeper inequities in economic ownership in the society, ushered in a decade of economic and political crisis.

2.1.3 1997-2008: the crisis period

With the onset of land reform and the decline in output of the commercial farming sector and the resulting decline in exports and inputs for the manufacturing sector, as well as the growing budget deficit and foreign exchange shortages, the Zambian economy started to decline precipitously. The various attempts by the Government, including the development of the Millennium Economic Recovery Plan (ZMERP) in 2000 and the National Economic Revival Programme in 2003 (NERP), could not reverse the decline.

As shown in Figure 3, between 1998 and 2006, Zimbabwe's GDP declined by 37 per cent in comparison to cumulative gains of over 40 per cent elsewhere in Africa. The implosion of the economy translated into declining government revenue. The response of the Reserve Bank of Zimbabwe, in effect to print money, had the effect of accelerating inflation. Zimbabwe became the first country in the twenty first century to experience hyperinflation with the official inflation rate peaking at 231 million per cent in 2008. (See Figure 4)

The 2003 Poverty Assessment Study Survey (PASS) showed a significant increase in poverty levels from the previous 1995 survey. As seen in Figure 5 the proportion of people below the Food Poverty Line (FPL) increased from 29 per cent in 1995 to 58 per cent in 2003 and the proportion of people below the Total Consumption Poverty Line (TCPL) increased from 55 per cent in 1995 to 72 per cent in 2003. Although no reliable national poverty data have been collected since then, it is widely believed that these levels have increased.

Figure 3: GDP Growth 1994-2007


Figure 4: Zimbabwe CPI inflation, annual average, 2001 to 2007


FOOTNOTES


The National Food poverty line is ZS 29,595 per capita per month and national total consumption poverty line is ZS 45,005 per capita per month, equivalent to USD 36 or USD 55 respectively. Food poverty line is derived by calculating the income required for an individual in a household to meet basic food requirements, equivalent to 2100 calories per person. The food poverty line is scaled up to obtain the Total Consumption Poverty Line reflecting the minimum monthly income required by an individual to meet both basic food and basic non-food requirement.
In rural areas where the majority of the population still reside, the population below the TCPL increased from 57 per cent in 1995 to 71 per cent in 2003, whilst in urban areas the population below the TCPL increased from 44 per cent to 61 per cent. Overall, although poverty has increased across the country, it has increased more rapidly in urban areas than in rural areas between 1995 and 2003.

One of the reasons for this increase has been the rise in unemployment rates which reached 63 per cent during this period. A large part of the unemployed population joined the informal sector with its associated precarious working conditions. Even the educated and skilled were not spared from this ordeal. A gender analysis of PASS results shows that at the national level, poverty incidence was higher among female-headed households (68 per cent) than male-headed (60 per cent). However, poverty increased more among male-headed households (54 per cent) than female-headed (44 per cent) between the 1995 and 2003 PASS.

The collapse of the economy, the hyperinflation and political standoff had an immense social cost in terms of rising poverty and unemployment, mass emigration, adoption of adverse coping strategies, advent of a public health crisis and decline in the other social sectors. The lack of livelihoods at home increased the levels of outward migration.11 Although there is no official figure on the number of Zimbabweans in the diaspora, University of Witwatersrand estimates that 1 to 1.5 million Zimbabweans reside in South Africa alone. with the majority being skilled professionals. The remittances from migrants became the lifeline for their families back home but their departure contributed to the collapse of social service delivery in Zimbabwe, in health and education in particular, as well as a shortage of skills critical to the economic recovery.

With the collapse of the economy and public finance, ordinary citizens were left to fend for themselves against mounting difficulties in order to meet their basic needs. Those professionals who decided not to leave the country were forced to adapt, with professors, lecturers, medical doctors and scientists operating minibuses, taxi cabs, or beer parlours.13 The less educated population took up adverse coping strategies that may undermine their long term development potential or cause irreversible damages. One study showed that rural households resorted to selling key productive assets, reducing food consumption and replacing healthy food with less nutritious but cheaper food items.14 Female headed households, households headed by children, the elderly and the chronically ill were the least able to deal with the protracted crisis.
During this period, Zimbabwe, once the food basket for the southern African region, became a net importer of food due to adverse weather conditions, land disputes and smallholder farmers not being able to access inputs and credit. At the height of the crisis, more than 5 million people were dependent on food aid in Zimbabwe. Perhaps the most spectacular example of the deterioration in the social sectors, however, was the cholera outbreak of 2008 and 2009. With 98,531 cases and 4,282 deaths, it was the worst outbreak of cholera in Zimbabwe’s history and underscored the extent of the deterioration in basic water, sanitation and health services. The education system was also in crisis, struggling with declining relevance and quality of the curriculum, falling teacher morale and loss of many trained teachers. In 2008, government schools effectively closed for an entire academic year as teacher salaries dropped to the equivalent of less than USD 2 per month. In addition to the major backslide on social indicators across classes, geography and ethnic lines, overall income distribution also worsened. The Gini coefficient in 2005 was 0.61, reversing the gains since independence. In this lost decade, Zimbabwe had little to boast in either improving the overall wellbeing of the population or narrowing the gap between the haves and have-nots.

Looking back, the period of 1997-2008 will be remembered as a period of unprecedented decline for Zimbabwe. Historically, Zimbabwe had some of the best basic social service systems in Africa. However, the socio-economic collapse during this period eroded these systems to a degree to which they were unable to consistently provide basic services such as health, water, sanitation and education.

2.2 2009-2010: Zimbabwe today
After thirty years of independence, Zimbabwe has come full circle in its pursuit of growth with equity. Income inequality, after a moderate decline between the 1980s and early 1990s, has swung back to its pre-independence level. Economic activity, which experienced an initial boom, shrank significantly at the height of the crisis. This deterioration was finally arrested in 2009.

2.2.1 Political Context
The signing of the Global Political Agreement (GPA) in September 2008 and the formation of the Inclusive Government (IG) in 2009 provided grounds for hope that a new era of recovery had begun in Zimbabwe. Several independent commissions on Media, Human Rights and Electoral reform have also since been constituted and staffed, if not yet fully functional. The IG is also spearheading the development of a new Constitution, through the Constitution Parliamentary Select Committee (COPAC), a coordination body chaired by representatives from each of the political parties. The process is explicitly “people driven” and, as of October 2010, had involved 4720 consultations, covering all districts in the country and involving nearly 1 million people. Additionally, over 4500 children contributed their ideas and wishes in the consultation process. A referendum has been scheduled for 30 June 2011 at which time the country will vote on whether to adopt the draft that emerges from this process.

2.2.2 Economic Growth and Development
The economy only began stabilizing with the introduction of a multiple currency system in 2009. Zimbabwe achieved negative month-on-month inflation rates for seven months throughout the year. In 2009 the economy grew by 5.7%. Revenue collection increased from USD 4 million per month in February to around USD 100 million per month in August 2009. “In his 2011 National Budget Statement, the Minister of Finance noted that revenue collection continued to improve in 2010 resulting in cumulative realization of US$ 1.8 billion by October 2010.” The projected growth for 2010 is currently 8.1 per cent.

The Inclusive Government launched the Short-Term Emergency Recovery Programme (STERP 1) in March 2009 in order to address the fundamental economic challenges affecting the country and to ‘resuscitate and rehabilitate the economy’. STERP had a nine month duration and focused on political and governance issues, social protection programmes and stabilisation, initiated through supply side and macro-economic

FOOTNOTES
11 The spectre of inflation remains, and the Ministry of Finance (MoF) in its First Quarter 2010 Treasury Bulletin warns, “The disinflationary gains of 2009 are now under threat as inflationary pressure started building up during the first quarter of 2010.”
12 The 2010 Mid-Year Fiscal Policy Review, Presented by the Minister of Finance, 14 July 2010
13 Medium Term Plan (Draft), Republic of Zimbabwe, 2010, p.15
14 This is the third time the Finance Minister has revised growth projections for 2010. While presenting the 2010 budget in December 2009, Biti had said Zimbabwe’s economy would grow by 7.7 per cent in 2010 but in July’s 2010 Mid-Year Fiscal Policy Review he revised the figure down to 4.8 percent.
15 Short Term Emergency Recovery Programme (STERP), Getting Zimbabwe Moving Again, Republic of Zimbabwe, March 2009, p.6
Country Context

reforms. STERP succeeded in reducing inflation, increasing business activity, removing price distortions and improving the management of public resources.

Five months into the implementation of STERP, the Government developed two critical policy documents to succeed STERP: the Three Year Macro-Economic Policy and Budget Framework (2010-2012), which began at the end of 2009 and the Medium Term Plan (MTP) (2010-2015), which is yet to be officially released. The Three Year Macro-Economic Policy and Budget Framework lays out the macro-economic policy instruments that will anchor the rolling budget for three years and bridge the gap between STERP and the MTP. The latter is based on the need to move the country’s economic reforms beyond macro-economic stabilisation towards sustainable growth and development, as well as structural and social transformation. Its objectives include restoring basic services, ensuring food security and support for rapid growth and employment creation.

The economic growth achieved in 2009 and projected for 2010 is a remarkable achievement and provides the foundation for Zimbabwe's recovery. However, the country’s external debt totaled USD 6.9 billion at the end of 2010\(^2\). External payment arrears,

"As children, we are often excluded when decisions about our lives are being made. We hope that this new constitution will guarantee every right that we have as children and to ensure that we do not suffer because of the choices, decisions and beliefs of our parents or elders."

Simba Chikukwa, 13 years, COPAC Children's Summit, September 2010
which started accumulating in 2000, amount to USD 4.7 billion. In addition, the current account gap is projected to be significant in 2010, with projected imports of USD 3.6 billion against projected exports of USD 2.1 billion. While the full extent of the arrears accumulation is hard to quantify, the Government has initiated a debt validation and reconciliation programme to tackle the issue\textsuperscript{21}.

As Zimbabwe’s economy recovers, a critical issue for the Government to emphasise is the importance of growth with equity, to avoid the widening of the gap between the different wealth quintiles.\textsuperscript{22} Growth must be broad-based, inclusive and sustainable.

There are no disaggregated, comparative data, but it is safe to assume that women and children were the hardest hit by the impact of hyperinflation and the collapse of social services. Women bear the burden of ensuring family survival and when basic goods are limited or completely unavailable, they are the first to suffer with the introduction of extreme household coping mechanisms.

There also exists a huge gap between the rich and poor in the entitlement to political, civil and human rights. There also exists large disparities in incomes and access to education, health and land, as well as to basic needs, including: clean water, adequate housing and sanitation.

Medium Term Plan, GoZ

Figure 6 shows the budgetary allocations to the different Ministries providing services to children over the past ten years. There was a significant decline from 2005 to 2008 and although there was an increase last year, the allocations across all the relevant ministries remain at the same level or below the 2007 allocations, except for the MoHCW where there was a slight increase in allocation.

\textbf{Figure 6: Social Public Expenditure (per cent of Budget) by Sector, 2000-2010}\textsuperscript{23}


\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{figure6.png}
\caption{Social Public Expenditure (per cent of Budget) by Sector, 2000-2010}
\end{figure}

\footnotesize
\textbf{FOOTNOTES}

\textsuperscript{20} 2011 National Budget Statement, Ministry of Finance
\textsuperscript{21} 2011 National Budget Statement, Ministry of Finance
\textsuperscript{22} Meeting with Permanent Secretary Ministry of Economic Planning and Investment Promotion, Dr D. M. Sibanda, 17 August 2010
\textsuperscript{23} Figure 6 represents budget allocations; not funds received.
Country Context

The lack of public financing in social sectors forced hospitals and schools to rely on user-fees to recover their costs. The inequities in access to social services widened in many cases as the poor and rural population bore the brunt of the crisis. Figure 7 shows a snapshot of inequity in health, education, water and sanitation using 2009 MIMS data.

The international community has been forthcoming in terms of meeting the unmet humanitarian needs of the population. As illustrated in Figure 8, donors provided USD 278 million for development assistance in 2006 which more than doubled in 2008. Increasingly donors have moved from providing purely humanitarian assistance to supporting recovery and transition. However, under the current political dispensation, most donors continue to channel aid through the UN system.

2.3 Aid coordination and evidence-based strategic planning

Due to the ongoing shift in relationships between international donors and the Government, aid coordination, in respect to the 2005 Paris Declaration and 2008 Accra Commitment for Aid Effectiveness, is still weak. Although the 180 days STERP was a starting point for a common framework, the Government still strives to develop a national Strategy for Economic Growth and Poverty Reduction. A 2010-2015 socio-economic mid-term plan is under development. With recent adoption of a Sector Plan for Health and Education, the sector partnerships framework is being strengthened, although the practice of child budgeting is still limited.

Figure 9 presents the national structure of aid coordination established through the Aid Coordination Policy adopted by Government in May 2009.

The structure of the Aid Coordination Architecture is as follows:

1) Cabinet Committee on Aid Coordination- Chaired by the Prime Minister
2) Aid Technical Committee-Chaired by Secretary for Economic Planning and Investment Promotion
3) Government Development Forum-Chaired by the...
Minister of Regional Integration and International Cooperation

4) Aid Technical Unit - Located in the Ministry of Finance

The Government Development Forum (GDF) serves to promote dialogue between Government and development partners, minimizing duplication and aligning aid with national priorities. Given the country’s financial constraints, development partners' funds play a crucial role in the country’s early recovery. Whereas additional funds are required by Government to achieve its set targets, there is need to effectively coordinate and manage the current aid inflows through the aid coordination architecture. All financing instruments necessary for early recovery and reengagement, such as the Multi Donor Trust Fund (MDTF), a possible needs assessment, and the resultant transitional agreement are yet to be agreed upon.

Regarding evidence-based strategic planning, the Zimbabwe Statistics Agency (ZIMSTAT, formerly known as the Central Statistics Office), was established in 1929 to collect, analyze and disseminate official statistics on the demographic, social and economic situation, governed by the Census and Statistics Act and more recently, the Statistics Act. In addition to ZIMSTAT, line ministries, public institutions and private organizations produce data related to their functions. Over the years, however, inadequate human and financial resources contributed to weakening the capacity of ZIMSTAT and other data producers to effectively deliver on their mandates. In particular, both the quantity and quality of data on social and economic indicators declined, limiting the ability to both develop and monitor development policies and initiatives.

In order to address these and other weaknesses of the National Statistical System (NSS), the government has agreed to (i) reform the NSS to make it more effective, efficient and responsive to data requirements for informing national development policies, processes and programmes, (ii) implement a more holistic and integrated approach to the development of statistics, and (iii) develop a National Strategy for the Development of Statistics (NSDS). Efforts will focus on making ZIMSTAT semi-autonomous in order to enhance the validity and credibility of official statistics, as well as

![Figure 9: National structure of aid coordination](source: Aid Coordination Policy (Cabinet of Prime Minister, May 2009))
the effectiveness and efficiency in the production and management of official statistics, and the governance of the NSS.

National reporting on the MDGs was completed in 2007 and 2010. Data from the 2005 DHS and Multiple Indicator Monitoring Survey (2009 MIMS) were useful to ensure the evidence of impact and outcomes progress. Strengthening investments on data collection through national household surveys to enable in-depth analysis on equity for evidence-based pro-poor policies remains a priority. A key focus area for partnerships should be to promote the use of data for decision making, improving governance and gender mainstreaming, targeting vulnerable groups and identifying policy options for improving the situation of children and women.

2.4 Outlook for the country: Recovery with equity

The country needs to consolidate the gains made in terms of the stabilization of the economy while promoting economic growth with equity, the theme of the first National Development Plan and highlighted again in the latest draft of the Medium Term Plan. The Inclusive Government has committed itself in its draft Medium Term Plan (MTP) for 2010-2015 to taking forward a national vision of good governance, the maintenance of political stability, access to services and equal opportunities for all. The MTP programmes include the promotion of pro-poor growth through targeted poverty reduction programmes, and a focus on restoring social services and achieving gender parity in access to education, health and other social services and welfare programmes.24 This is a strong demonstration of political commitment to address the critical issues facing children and women.

Already there are positive signs for development and for the women and children of the country: inputs for small-holder farmers are now widely available, the projected population dependent on food aid has reduced to 1.3 million for the 2010-2011 hunger seasons. Although fiscal space has constrained civil service wages, resulting in ongoing threats of industrial action, teachers, doctors and nurses are back at work and the health, education and water and sanitation sectors have gradually stabilized. The 2009-2010 rainy season resulted in less than 100 cases of cholera compared to around 100,000 cases in the previous year and a major outbreak of measles occurring in 2009-2010 was dealt with through a successful national campaign.

The recently released 2011 Budget Estimates provides additional optimism for the recovery of social sectors in Zimbabwe. Expenditure on social sectors has not only rebounded in absolute terms (from US$ 639 million in 2010 to 926 million in 2011) but also as a percentage of the overall government expenditure (28.4 per cent to 33.7 per cent) and GDP (11.4 per cent to 15.2 per cent). However, the sectoral recovery remains uneven. While education expenditure is close to the Abuja Declaration’s target of 20 per cent, health expenditure falls short of the 15 per cent target, leaving a gap with significant implications beyond 2011. Social protection expenditure is projected to hover around US$ 30 million a year or 1 per cent of government expenditure from 2010 to 2012, leaving a large funding gap between increasing needs for social protection and limited resources.

Looking forward, the effects of HIV on social and economic development will diminish as HIV prevalence declines and increasing numbers of people living with HIV obtain treatment. Rainfall patterns will continue to be a concern as agriculture capacity utilization remains at a historically low level. The global financial crisis and its aftermath are unlikely to impact Zimbabwe in any significant way given the decoupling of the national economy from the rest of the world economy.25 As a result, the country’s outlook is most likely to be driven by the evolution of the political situation including the timing, conduct and outcome of the next elections, the strength of the economic recovery, the likelihood of growth translating into employment and government revenues, and external aid flows.

---

FOOTNOTES

24 Medium Term Plan (Draft), Republic of Zimbabwe, 2010
25 Exception would be the remittance channel, in particular the health of the South African economy where the majority of Zimbabwean emigrants work.
3. Care and protection of children and women from violence, abuse and exploitation

All children and women have the right to be protected from harm. Preventing and responding to violence, exploitation and abuse is essential to ensuring children’s and women’s rights to survival, development and wellbeing. This chapter addresses legislation, services, capacity and enforcement as elements of children’s and women’s protective environment in Zimbabwe.

3.1 Social, historical, economic and political context

The African Charter on the Rights and Welfare of the Child (ACRWC), the Convention on the Rights of the Child (CRC) and the Convention on the Elimination of all forms of Discrimination against Women (CEDAW) enshrine the right of all children and women to live in a respectful, supportive family environment that is free from violence, abuse, exploitation and discrimination. These instruments highlight the primary responsibility of parents and extended family in the care of children. Protection failures, including violence against women, also carry broader human, social, and economic costs.

In Zimbabwe, protection is largely influenced by poverty, the negative impact of HIV and AIDS, the deterioration of the welfare and justice systems, violence, exploitation and abuse of children in families and communities. The latest official poverty statistics indicate that approximately 3.5 million children live below the food poverty line in Zimbabwe, and are in urgent need of quality protection and free access to basic services. Recent research indicates that between 220,000 and 250,000 rural households in Zimbabwe live in extreme poverty and are food insecure. These households include between 620,000 and 700,000 vulnerable children.

These children struggle to access basic services, such as health, education and social protection. As a result, many children, particularly adolescents, are forced to work, often under exploitative conditions, to meet their basic needs. Unsafe migration, child trafficking, child prostitution, child labour and other forms of abuse pose special challenges for this marginalised community of children.

The HIV epidemic remains one of the largest drivers of widespread poverty in Zimbabwe and one of the most devastating effects is the large number of orphans. Estimates suggest that a quarter of all children in Zimbabwe, around 1.6 million, have lost one or both parents due to HIV and other causes. As a result,
many orphans are cared for by their extended families, including grandparents (generation gap households), or are living in one of the 100,000 child headed households.\(^ {33} \)

A comparison of orphanhood using data from the Zimbabwe Demographic Health Survey (DHS), 1999 and 2005-6, and MIMS data of 2009, indicates increased orphanhood. Figure 10 shows both an increase in children who have lost only one parent, and those who have lost both parents.

The decline in HIV prevalence and increased access to anti-retroviral treatment will take time to result in a decrease in the number of orphans. While some estimates\(^ {34} \) indicate that the number of orphans may be slightly decreasing, the proportion of orphans per capita remains one of the highest in the world. These trends are presented in Figure 11: Epidemic curves showing population numbers for HIV prevalence and AIDS orphans in Zimbabwe.

Zimbabwe 2005-2006 DHS data were analysed to establish if orphaning or co-residence with a chronically ill or HIV positive adult resulted in adverse outcomes. The findings were unequivocal. Orphanhood alone results in decreased school attendance and earlier sexual debut.\(^ {35} \)

Recent focus group discussions with children revealed that many orphans live in extremely poor households and are less likely to access health care, attend school or have basic clothing, shoes and bedding than other children from the same communities.\(^ {36} \)

Confirming regional studies, local evidence shows that they are also more likely to suffer from psychological problems and to be subjected to abuse, including forced sex in adolescence, which increases their likelihood of contracting HIV.\(^ {37} \)

---

**Figure 10:** Increase in Orphan Numbers in Zimbabwe between 1995 and 2005

*Source: DHS, 2005-06; CSO March 2007*

![Diagram showing increase in orphan numbers](image)

**Figure 11:** Epidemic curves showing population numbers for HIV prevalence and AIDS orphans in Zimbabwe


![Diagram showing epidemic curves](image)
Despite the gravity of their situation, little external support reaches orphans and other vulnerable children.\textsuperscript{38} It should also be noted that not all orphans in Zimbabwe are poor and not all poor children are orphaned. There are a sizeable number of children who have experienced abuse, exploitation, violence and discrimination for reasons that are largely independent of their individual HIV or economic status.

To support poor families to cope with the risks and shocks outlined above, the Government of Zimbabwe has become well-regarded in the region for its sophisticated social protection strategies. In the 1980s and 90s, the Government established and updated a number of government-run social protection mechanisms, the most well-known being the Drought Relief, Child Supplementary Feeding and Agricultural Recovery Programs and the Social Development Fund. These safety nets were designed to support those in transitional poverty, rather than the chronically poor, and are considered to have been relatively successful. The chronically poor were supported through Public Assistance, although today the program receives a relatively low budget allocation. Other social protection efforts included primary and secondary school assistance (Basic Education Assistance Module, BEAM) for the poorest children and health insurance (Assisted Medical Treatment Orders, AMTO) for vulnerable families.

Government support to people with disabilities, particularly in the mid-1990s, is an example of Government commitment to supporting the most vulnerable, with an effective community rehabilitation program providing trained staff in district hospitals and equipping resource rooms in schools with specialised staff. These important schemes, as well as the Enhanced Social Protection Program launched in 2000, have suffered from a severe lack of human and financial resources in the last decade and are in urgent need of review and revival to meet the growing needs of children.

The DHS (2005-2006) provides a clear indication that the experience of violence is a significant problem for women in Zimbabwe. Although comprehensive data is lacking on the prevalence and incidence of sexual and physical violence against children in Zimbabwe, emerging anecdotal evidence and local studies by UN agencies and NGOs suggest that violence of all types is a significant issue, particularly for girls and other vulnerable children, including orphans and children living away from their family, children on the move, children with disabilities and children who come into conflict with the law.

### A Statistical Snapshot of Violence against Children and Women

- 25 per cent girls affected by HIV are exposed to sexual violence before their 18th birthday (National AIDS Council)
- 22 per cent of children report experiencing abuse by a caregiver (My Life Now Draft Report, 2010)
- 36 per cent of women have experienced physical violence since they were 15 years old (DHS 2005-06)
- 21 per cent of women report that their first sexual intercourse was forced against their will and 25 per cent report they have experienced sexual violence at some point in their lives (DHS 2005-06)
- 47 per cent of women report having experienced physical or sexual violence (DHS 2005-06)
- 13 per cent of girls report being sexually harassed by teachers and/or fellow pupils. Of these, 7 per cent report having been forced into sex at least once (Research Report on Child Abuse in Schools: A Baseline Study for the "Learn Without Fear Campaign", Plan Zimbabwe, September 2009, research carried out in 5 districts in 3 provinces)
- 25 per cent of boys living and working on the streets of Harare are victims of sexual abuse, and only 8 per cent of these boys were able to report that the perpetrator had been arrested (The nature and prevalence of violence and sexual abuse among boys living and working on the streets of Harare, Save the Children Norway, Childline, Streets Ahead, 2009)
- The Police recorded 3,448 child abuse cases in 2009, the Victim Friendly Courts heard 1,222 cases of child sexual abuse and it is widely recognised that a majority of abuse is not reported to authorities (VFU Annual Report 2009)
- 67 per cent of children and 35 per cent of teachers concur that corporal punishment is used by all teachers at one point or another during school time (Research Report on Child Abuse in Schools: A Baseline Study for the "Learn Without Fear Campaign", Plan Zimbabwe, September 2009)
3

Care & Protection of Children and Women from Violence, Abuse and Exploitation

Childline Zimbabwe’s Child Abuse Report

Childline, in partnership with UNICEF and the Collaborative Centre for Operational Research and Evaluation (CCORE), collected data on all 6,118 calls and visits handled by Childline in 2009. Forty-one per cent constituted actual cases falling into at least one of the categories of child abuse as illustrated in Figure 12: Rates of reported abuse against boys and girls. There was little difference in proportion between girls and boys for neglect, physical abuse and bullying, but a significant difference for sexual and emotional abuse, with girls nearly six times more likely to be sexually abused than boys.

![Figure 12: Reported abuse against boys and girls by type](source: Childline)

The significant findings from the report included:

- 91 per cent of all cases of sexual abuse were classified as ‘rape’, with 46 per cent of the children reporting the abuse had occurred on multiple occasions.
- 74 per cent of the child survivors of sexual abuse reported that they knew the perpetrator, with 24 per cent of perpetrators originating from the immediate family and 37 per cent of perpetrators living in the same house as the survivor.
- 24 per cent of alleged perpetrators from reported cases were arrested. A court hearing date was obtained in 23.5 per cent of the cases, but only 8 per cent of the cases went to trial. The perpetrators were sentenced in 3.5 per cent of cases and imprisoned in 1.2 per cent of cases.

3.2 The protective environment framework

A protective environment is where women, girls and boys are free from violence, exploitation and unnecessary separation from family. It is an environment in which laws, services, behaviours and practices minimise children’s and women’s vulnerability, address known risk factors and strengthen children’s and women’s resilience. This is a human rights based framework that emphasises prevention, as well as the accountability of duty bearers including Government. This environment emphasises children’s and women’s participation and their own roles and resilience as change agents. The analysis below is intended to provide the foundation for the creation of a protective environment for children and women in Zimbabwe.

FOOTNOTES

40 UNICEF, Child Protection Strategy, UNICEF Executive Board Annual Session 2008
3.2.1 Legal, regulatory and policy frameworks and enforcement

A protective environment requires a comprehensive, rights-based regulatory legal and policy framework that includes accountability and redress mechanisms. This framework, together with the actors responsible for its implementation, must also be adequately resourced to ensure proper enforcement.

Zimbabwe is governed by a comprehensive legal and regulatory framework that includes legal protections that it has committed to provide through ratification of the ACRWC, the CRC and the CEDAW. The government is yet to ratify the two optional protocols of the CRC, including on Children and Armed Conflict and Child Trafficking. A review of the national legal framework conducted in 2004 concluded that Zimbabwe’s legislation ‘meets most of the standards of the CRC’. The administration of statutory child protection services is covered by the Children’s Act and the Criminal Code criminalises many forms of abuse and violence against children. Legislation has been passed which has raised the status of women, through the attainment of majority, the equitable devolution of matrimonial property and making the surviving spouse and children the primary beneficiaries in a deceased person’s estate. However, these provisions do not apply equally to all women and children and the benefits and protections of such legislation can be negated through the primacy of customary law and certain clauses within the Constitution. Other discriminatory legislation remains, reinforcing potentially harmful customary views, for example the Guardianship of Minors Act which provides a married father with the legal right of guardianship for the children, whereas the mother only has a right to be consulted.

Zimbabwe is signatory to a number of international and regional agreements on gender equality and development. A National Gender Policy 2008-2012 was developed and approved in 2007 but challenges remain for its implementation, as with the draft National Gender Based Violence Strategy 2010-2015.

Despite these advances, there remain some critical gaps in the domestication of international conventions, including the ACRWC, the CRC and the CEDAW, leaving children and women unable to claim their rights or adequately seek redress when their rights are violated. Zimbabwe is yet to sign the Convention on the Rights of Persons with Disabilities. Enforcement remains a challenge in a context in which communities, government and non-government agencies lack the financial, human and technical resources to implement legislation. In 2008, the African Child Policy Forum ranked Zimbabwe amongst the poorest performing 10

FOOTNOTES
41 UNICEF, Children and Women’s Rights in Zimbabwe Theory and Practice, 2004
42 Such legislation includes: The Legal Age of Majority Act (now the General Law Amendment Act); the Matrimonial Causes Act and the Administration of Estates Amendment Act 6:01
43 Guardianship of Minors Act clause 3 states: ‘the rights of guardianship of the father shall be exercised in consultation with the mother’. Other discriminatory legislation includes: the Marriages Act, which sets a lower minimum age for marriage for girls than boys; and the Deeds Registries Act, which requires married women to be assisted by their husbands when registering land title.
44 These instruments include: The Beijing Declaration and Platform for Action, the African Union Solemn Declaration on Gender Equality in Africa and the SADC Declaration and Protocol on Gender and Development
45 Ministry of Women’s Affairs, Draft National GBV Strategy, 2010

Our rights?

"Though measures are being taken to implement children's rights, they tend to be sporadic developments. Even more, the very children are alien to their rights - they are not aware of their very fundamental rights."

(Child’s view expressed during Save the Children Norway Child Rights Governance Program 2010)
African countries in implementing the legal and policy frameworks to protect children against harm and exploitation.

The widespread use of corporal punishment is a good example of an issue that contravenes the provisions of the CRC, but remains protected by legislation and the failings of the regulatory framework. The Constitution does not currently provide explicit protection for the rights of children, and combined with the Public Service (Disciplinary) Regulations and the Criminal Procedures and Evidence Act, provides legal protection to adults who administer corporal punishment to boy children. In 1990, the Supreme Court of Zimbabwe described juvenile whipping as 'inherently brutal and cruel' and ruled that it was an inhuman and degrading punishment, which violated the Constitution. However, Constitutional Amendment number 11, adopted the following year, revised the relevant section of the Constitution to expressly allow moderate corporal punishment for males under the age of eighteen. The United Nations Committee on the Rights of Children has since recommended the Government of Zimbabwe to 'adopt appropriate legislative measures to forbid the use of any form of corporal punishment within the family and in any school'.

There are regulations that limit the use of corporal punishment in schools, but the enforcement of these regulations remains inconsistent. A study commissioned by Plan Zimbabwe concluded that 'corporal punishment is usually administered, unrecorded, unreported and usually unbeknown to the school head'. In this study, the recorded incidents of corporal punishment in the surveyed schools from three provinces found that an average of seven incidents were recorded in each school during the period 2000-2009. However, about four in every five child respondents during the study had suffered corporal punishment in the second term of 2008 alone. Many teachers and parents believe that corporal punishment is a reasonable form of discipline and there are anecdotal accounts of parents bringing children to the head teacher and requesting them to administer corporal punishment on their behalf to help instil discipline. This view is not held by all parents and in other cases, parents are required to sign consent forms allowing corporal punishment to be administered, particularly for private or church schools, with enrolment potentially denied if they refuse.

The widespread use of corporal punishment is also a reflection of the current professional capacity and morale of teachers. Teachers cite their decline in motivation as a factor underlying the administration of corporal punishment. In addition, the majority of current teacher trainees have not been exposed to the regulations governing the use of corporal punishment.

3.2.2 Government leadership and commitment to protection

Government leadership and commitment is demonstrated by the prioritisation of child protection by leaders at all levels, together with public declarations of support and intent, the ratification and domestication of international conventions and adequate budgetary provisions for child protection.

The Government has responded to many of the recommendations made by the Committee on the Rights of the Child in the Initial State Party Report. The Second Periodic Report updates progress and includes details of some of the challenges faced with the implementation of the CRC. Fourteen years have elapsed since the submission of the initial report and this second report drafted in 2008-09 is awaiting Cabinet approval. The Initial Report to the CEDAW Committee was submitted in 1996 and the latest report, awaiting Cabinet approval, combines three reporting periods due to the time that has elapsed.

A landmark strategy, the National Action Plan for Orphans and Vulnerable Children (NAP for OVC), was adopted in 2006 to guide Government and its partners in the response to the needs of the most vulnerable children. The NAP for OVC is a government social
The next phase of the NAP (2011-2015) will focus on household poverty as a key driver of children's suffering and deprivation in Zimbabwe. The NAP II will scale up the Government’s national cash transfer system to increase the incomes of extremely poor households, enhance access to effective child protection services, including social welfare and justice, and facilitate access to basic social services. The growing fiscal support to social protection is indicative of the favourable policy environment and the strength of government commitment in this critical child protection area.\(^{56}\)

**Preliminary results from the NAP/ PoS Cash Transfer Pilot in Manicaland\(^ {60}\)**

Cash transfers may help orphans and other vulnerable children who have been affected by the economic decline and high HIV prevalence in Zimbabwe. A community-randomised controlled trial of a pilot cash transfer program in Zimbabwe is being conducted in the eastern province of Manicaland to investigate the effects of cash transfers - both conditional and unconditional transfers - on the wellbeing of children living in vulnerable households. In a preliminary survey of 653 children benefitting from the cash transfer pilot, children in cash transfer communities were more likely than children in control communities to have birth certificates, to be fully vaccinated and to attend primary school and secondary school regularly. Despite the limited sample size, the improvements in birth registration and school attendance were statistically significant. In interviews and focus groups, beneficiaries confirmed that the greatest changes caused by the cash transfers were increased birth registration and school attendance. This programming intervention is therefore being scaled up in the future Programme of Support to the National Action Plan for Orphans and Vulnerable Children using the targeting outlined in Figure 13: Targeting for future Programmes of Support.

**Figure 13: Targeting for future Programmes of Support**

*Source: UNICEF*

---

**Footnotes**


55. Article 44 of the CRC commits State Parties to report every 5 years.


58. This cash transfer pilot is funded by the Programme of Support (PoS), and implemented by Catholic Relief Services, BRTI, Imperial College London with UNICEF and MoLSS management.
In other countries in the region, social cash transfers have demonstrated ability to a) increase school enrolment amongst beneficiary children, b) increase access to basic social services such as healthcare, c) reduce hunger and improve household food security, d) reduce child labour and e) address gender disparities by empowering adolescent girls to safely negotiate sexual partners and reduce HIV-risk behaviours.57 Recently, they have also been documented to have an economic multiplier effect, benefiting communities and the economy at large.58 Cash transfers, when part of a nationally embedded social protection system, are often cheaper to deliver and easier to administer, compared with in-kind benefits. They also give beneficiaries the power to decide how best to use resources to meet given needs and although cash transfers are not a panacea, they are increasingly seen as the 'critical lever' in the social protection agenda for children.59

To specifically address the discrimination and inequality that women and girls face in Zimbabwe, the Ministry of Women Affairs, Gender and Community Development was established in 2005 and is responsible for the leadership and national coordination of all gender-based violence interventions. However, this Ministry continues to be under-resourced, which negatively impacts on its abilities to act nationally and in communities.

There are a number of other Government-led, inter-agency coordination mechanisms in place that complement the broader child protection agenda, including the Victim Friendly Court Committee, the Inter-Ministerial Committee on Human Rights and, at the local level, child protection committees. Ensuring that these mechanisms are adequately resourced will ensure that child protection remains a priority for decision-makers and other influential leaders.

3.2.3 Rights-based customs

Rights-based customs are those which underpin an environment which is not discriminatory to children and women, where harmful practices such as sexual exploitation and discrimination are not socially accepted, protected and encouraged by religious or traditional beliefs.

Traditions and customs, most of which (such as the prioritisation of family and respect for the elderly) serve to protect children and women from harm and promote their social development, remain important to all Zimbabweans. As in all countries, however, some traditional views and customs continue to encourage and permit violence, abuse and discrimination. For example, women and children continue to experience a lower status to that of men within many private and public realms, which reduces and limits their access to resources and constrains their influence in decision making at all levels.60 Polygamy is still legal and the payment of lobola (bride price/wealth) is still widespread, although opinions are divided on whether lobola decreases or increases the status of the bride.61 Similarly, custom in some communities precludes women and girls from inheriting family resources and this practice remains protected by the Constitutional provision that permits discriminatory practices if they are based on established custom.62 There is no legal age for marriage within the Customary Marriages Act and early marriage before the age of consent remains normalised in some communities.

Some traditional attitudes defend male perpetrators of sexual violence as unable to control their sexual desires, particularly when the survivor is perceived to

FOOTNOTES

60 Thabethe, N., SADC Gender Protocol Barometer Baseline Study, Zimbabwe, 2009
62 Constitution of the Republic of Zimbabwe, Section 23
Since 2006, the Ministry of Labour and Social Services (MOLSS) has coordinated a National Action Plan for Orphans and Vulnerable Children (NAP for OVC). The NAP comprises seven activity areas: coordination, child participation, birth registration, formal education, social services (e.g., psycho-social support; water and sanitation; health, nutrition and hygiene education; shelter), extra-curricular education and livelihoods support and child protection.

The USD 86 million, multi-donor Programme of Support (PoS) was established to coordinate and scale up international support for the NAP. It aimed to address the needs of the large number of orphans and other highly vulnerable children in Zimbabwe (2006-2010). The MoLSS has the overall responsibility for coordination and partners with UNICEF and 33 NGOs which undertake activities through 150 local organisations. By June 2010, 441,400 (234,938 female and 206,462 male) children were reached through the PoS. As illustrated in Figure 14: Coordination of OVC response through the Programme of Support, the PoS developed a model for partnership between NGOs, Government and the UN to coordinate multi-sectoral efforts for orphans and vulnerable children.

An independent impact assessment of the PoS found consistency with the priorities of OVC beneficiaries and the country's development needs, government ownership and good geographical and thematic coverage. The PoS has been implemented with a strong cost-consciousness, resulting in the bulk of funding going to civil society and directly to children. Challenges included a fragmented approach to addressing the varied needs of OVC, with a focus on 1 or 2 areas despite multiple and inter-related deprivations; a focus on the number of children reached, rather than the quality of services delivered; and inadequate coordination at provincial, district and ward levels.

The aim of phase two of the PoS (2011 and beyond) - PoS 2, is to ensure that the most vulnerable children in Zimbabwe secure their basic rights through the provision of quality social protection and child protection services by 2015. PoS 2 will focus on social cash transfers targeting labour constrained households and increased child protection support services to vulnerable children.

PoS 2 will emphasize building Government capacity to lead, coordinate, regulate and monitor child and family protection service delivery at national, provincial and district levels. A comprehensive, case management approach will be introduced through which district social workers will address the needs of vulnerable children. Targeting will focus on the family around the most vulnerable children and the quality of services provided will be measured together with the number of children reached.

This model of programming and delivery, which enables greater donor, inter-ministerial and civil society coordination, is now recognised as a model of good practice in the region.
be dressing or behaving seductively. In transferring responsibility to the survivor, these attitudes can serve as a disincentive to report abuse or seek support.

The belief that violence against women is acceptable under some circumstances has become so engrained that a higher percentage of surveyed women (48 per cent) than men (37 per cent) in the last DHS agreed that it was reasonable for a husband to use violence against his wife if she fails to meet her gendered roles (such as neglecting children, arguing, rejecting sexual advances, burning the food or going out without first informing her husband). The prevalence of these beliefs differ across the age brackets, with 15-19 year olds representing the highest percentage of men who agreed violence was reasonable. Collectively, this data indicates that behaviour change strategies will only be effective if their design takes into account gender and age differences. Figure 15: Percentage of women age 15-49 who have experienced different forms of violence in Zimbabwe shows the difference forms of violence experienced by women.

Some communities and families in Zimbabwe condone violence as a means of resolving disputes and exercising control, to the extent that violence against

**The Cost of Gender Based Violence in Zimbabwe**

A 2010 study shows that Gender Based Violence (GBV) imposes a huge burden on survivors and to society as a whole, since it hinders development and constrains poverty reduction efforts. The study revealed the wide range of different social and material costs of GBV: medical, justice, transport, school fees, STI and HIV infection, trauma, loss of childhood, opportunity loss in education, loss of household income, child care, counselling and the loss of productive years of labour. The study estimated that the resources spent by the Government and society on GBV could finance the primary and secondary education for all students in rural areas. The aggregated cost of GBV to Zimbabwe in 2009 was estimated at USD 2 billion, which included the direct costs incurred by survivors and providers, as well as the indirect and multiplier costs. The real cost is likely to be higher, as many costs are difficult to quantify.

Source: "The Cost of Gender-Based Violence in Zimbabwe: Issues and Policy Options", SIDA,

---

**Footnotes**

65 ZDHS, 2005-06, pp.247-250
women is seen by the perpetrator, the survivor, the community and the state to be the norm. However, there is a growing movement to address gender inequities and challenge behaviours and attitudes that condone violence. The Ministry of Women Affairs, Gender and Community Development is now playing a coordinating role within government for all gender based violence programming and the Ministry of Health and Child Welfare is actively engaging with traditional and religious leaders to use their influence and positions of authority in communities to strengthen safe, protective cultural practices and reject those that are contrary to child rights. As with all attitude and behaviour change efforts, this requires concerted, resourced and coordinated advocacy by government, civil society and partners.

3.2.4 Open discussion and advocacy

Child protection concerns, such as sexual violence, trafficking, migration and discrimination on the basis of disability or HIV status, remain difficult for families, communities, government and partners to discuss, as do issues around domestic and gender based violence. For example, the reporting of sexual abuse is constrained by the fear of stigmatisation. One survey reported that 39 per cent of families kept their child's experience of sexual abuse secret from the community, although in about half of the cases where the abuse was known, support was provided by community members. This survey showed that half of the abused children do not report the abuse themselves, but it is detected through the contraction of an STI, pregnancy, physical injuries or reports by eye witnesses. In a survey of 669 households with 779 children with disabilities, only 8 cases of sexual abuse were identified, but the survey report suggested, 'this is likely due to the secrecy surrounding sex in general, and particularly sex with minors, rather than the absence of the problem.'

The Government is currently in the process of preparing a number of key research studies to examine the nature and scope of these problems, with a view to increasing their prominence in social policy debates and their visibility in communities. For example, in 2011, the Government is partnering with UNICEF, the Centre for Disease Control (CDC) and the Collaborative Centre for Operational Research and Evaluation (CCORE) to undertake a national prevalence study on child abuse, including sexual abuse of girls and boys. A study on children's access to justice was initiated in 2010. Forums for discussing sensitive issues are also becoming increasingly available to a wider range of actors. For example, MoLSS is spearheading a task force for children on the move, including those who cross borders, to document risks, identify strategies to support safe migration and, where possible, prevent unnecessary movement from major migrant-sending districts.

3.2.5 Protective essential services

Children and women require welfare, justice and other basic social services to be available, accessible and of sufficient quality to prevent protection rights violations and, where necessary, to intervene to restore safety and protection. This requires services to be functioning and provided in an equitable way, so they are accessible to vulnerable groups such as detainees or displaced children.

**FOOTNOTES**

66 MoWAGCD, National Gender Based Violence Strategy document and Action Plan, 2005
67 Meursing,K. et al., 1995. Child Sexual Abuse in Matabeleland, Zimbabwe, Social Science and Medicine Vol. 41, No.12 Survey of 54 children with their parents or guardian presenting themselves to the 2 Bulawayo hospitals with signs of abuse, together with 10 focus group discussions of 6 - 15 participants.
68 Ibid
The child protection system is powered by the social welfare and justice systems. The MoLSS is responsible for overall implementation of the Children’s Act. The Zimbabwe Republic Police (which falls under the Ministry of Home Affairs) and the Ministry of Justice and Legal Affairs, administer the formal legal system, including law and order, and correctional services. Each of these services is functioning, albeit to varying degrees. For example, there are currently only 96 district social workers nationwide performing all government social work and probation functions. These professionals are situated in Harare or the provincial or district capitals and other urban areas. With around more than a million children affected by HIV/AIDS and hundreds of other abused children undocumented and in need of specialised social welfare support the reach of government services is highly limited. Indeed, the ratio of care workers to children is amongst the lowest in the region (see table 2).

To address this shockingly wide gap, the Social Work Council and MoLSS intend to implement legislation that will enable all registered social workers to be appointed as probation officers. While this will increase the reach of services, it could also significantly increase the workload of social workers. Until this time, however, a majority of essential services are still being delivered by non-governmental organisations with little government oversight, preventing the delivery of a standardised and comprehensive service delivery model. Ultimately there is a need to provide sufficient resources and capacity to the MoLSS. Only then can it be held accountable for the delivery of its mandate. Findings from a 2010 audit of the Department of Social Services, within MoLSS, will determine the nature of such capacity building and institutional strengthening in the future.

The Victim Friendly System is a long running and potentially national scale service for vulnerable children and women. This system seeks to deliver comprehensive, specialised psychosocial care and medical, legal and referral services to survivors of sexual abuse through Victim Friendly Police Units (VFU), Courts and Clinics. In 2009, 5,768 children were reached directly through the Victim Friendly Courts, police and hospital clinics.

Currently Victim Friendly Police Units are situated in 10 provincial headquarters, 43 districts offices and 267 police stations at sub-district level. The majority of reported cases to this police unit involve children (64 per cent of 3,239 cases in 2009). Victim Friendly Courts have been established in 17 regional courts, offering a child-sensitive environment for children who have experienced or witnessed abuse. Prosecutors, intermediaries, probation officers and magistrates are trained to deal with children in a child-sensitive manner, work to expedite cases involving children and refer children to post-trial care and support services where

### Table 2: Ratio of Children to Social Workers in Selected Countries in Southern Africa

<table>
<thead>
<tr>
<th>Country</th>
<th>Population</th>
<th>Population of children</th>
<th>Total number of social workers</th>
<th>Ratio of children to social workers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Botswana</td>
<td>1.8 million</td>
<td>784,000</td>
<td>420</td>
<td>1,867:1</td>
</tr>
<tr>
<td>Namibia</td>
<td>2.0 million</td>
<td>860,000</td>
<td>200</td>
<td>4,300:1</td>
</tr>
<tr>
<td>South Africa</td>
<td>47 million</td>
<td>15,000,000</td>
<td>12,000</td>
<td>1,250:1</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>12.5 million</td>
<td>5,000,000</td>
<td>118</td>
<td>42,373:1</td>
</tr>
</tbody>
</table>

Source: MoLSS and UNICEF, DSS Audit, OPM, DRAFT Report, 2010

FOOTNOTES

70 MoLSS and UNICEF, DSS Audit, OPM, Draft Report, 2010
71 Ibid. Note that population figures vary in the literature and this table is drawn directly from the DSS Audit
72 Reports from the Victim Friendly Courts, 2009
73 Zimbabwe Republic Police, Victim Friendly Unit Police Annual Report, 2009
necessary. Child survivors or witnesses can be supported to give evidence outside of the court room and away from the alleged perpetrator through video link-up, or in a separate room. In the first quarter of 2010, 1,107 girls and 337 boys (a total of 1,344 children) and 756 women received support through the Victim Friendly Courts. Research is needed to know more about the quality of the services provided through these courts.

The Victim Friendly System has ambitious targets to see a 50 per cent increase in the rate of reporting by 2012 and to be providing specialised support, care and protection to 10,000 children a year. This will be supported by enhancing the existing database to enable key service providers to track and support child survivors from pre-, during- and post-trial, increasing the number of victim friendly courts to 30 (3 per province) and providing resources and training to legal, social welfare and judicial professionals to adopt rights-based case management and referral approaches when working with children.

While the Victim Friendly System offers an example of the success that can be achieved in the current context, the broader justice for children system continues to face a number of constraints (see Figure 16: Justice for Children System). There is no specialised juvenile justice system, although the Government is currently in the process of designing a pre-trial diversion program for children who commit non-violent property or other minor offences. Children who commit crimes are not eligible to access the Victim Friendly System and suffer from a lack of specialised legal and other assistance, although in many cases these children are victims of abuse and neglect themselves. The criminal age of responsibility for children is set at seven years, amongst the lowest in the world and which subjects children, particularly boys, to corporal punishment and imprisonment. A pilot diversion program is expected to commence in early 2011 in the three largest urban areas. There are currently only 17 legal aid lawyers, all of whom are situated in Harare and Bulawayo.

The absence of a national, resourced legal aid program, coupled with the low legal literacy of communities, also prevents many children and women from adequately accessing the family law system or seeking justice through the administrative and traditional systems.

FOOTNOTES

74 Powell, G., Children in residential care - The Zimbabwean Experience (presentation), 2005
Care & Protection of Children and Women from Violence, Abuse and Exploitation

What We Want
Empower families so that they can look after children on their own.

(Focus Group Discussions with children on the PoS, June 2010)

with disabilities and children who come into conflict with the law. Institutionalisation undermines the traditional modes of care, alienating children from their families, communities and culture. It heightens the risk of abuse and maltreatment and denies children their right to a supportive, family environment in which to develop and grow.

The Zimbabwe National Orphan Care Policy, developed in 1995, states ‘It is the policy of the government to move away from institutional care and children’s homes. Children’s homes should only be used as a last resort and as a temporary measure in transit to a more permanent placement in a family or family type environment.’ Unfortunately, the number of institutions and institutionalised children has doubled over the last ten years.76 Out of the 3,013 institutionalised children in 2005, 39 per cent had one or both parents alive and 59 per cent had contactable relatives, meaning that the majority of children in institutions at that time could have remained at home had there been support to their families.77 Faith-based organisations are responsible for 90 per cent of the new institutions and with most new homes being built in remote rural locations, outside the reach of existing probation services, oversight remains minimal. The 2005 survey showed that 40 per cent of the children in institutions had not had their cases formally reviewed in the last five years and 62 per cent of the children placed in residential care as a result of coming into conflict with the law did not have a valid court order.79

Hardship is also encouraging members of communities to move internally or across the border. Much of this movement is being undertaken by children who are unaccompanied, or otherwise at risk. While the exact number of children on the move is not known, at least 1,168 were referred to the Reception Centres at Beitbridge and Plumtree in 2009. Research conducted on the characteristics of children accessing the services offered by the Beitbridge Child Reception Centre from 2007-2009 showed that boys (mainly adolescent boys) made up 91 per cent of the children passing through the centre.79 However, the proportion of girls passing through the Beitbridge Centre in 2009 had increased to 18 per cent of the total children. The largest proportion of children (79 per cent) came from rural areas. Forty eight per cent of the children were orphans, demonstrating that factors other than orphanhood push children into migration. It should also be noted that this research does not represent data on the more ‘invisible children’ crossing borders, including girls who are trafficked and those too afraid, or who lack the knowledge to report to reception centres.

Economic opportunity was the main reason for crossing the border reported by 70 per cent of the children. Seventy one per cent of the children returning to Zimbabwe also intended to return to South Africa. The main protection concern reported was detention, with 81 per cent of the children reporting they had been detained.

A qualitative survey of 739 children from 10 towns across Zimbabwe noted that 18 per cent of children were being approached with a job offer or study opportunity outside of their district.80 The study concluded that most communities lack the knowledge and skills to prevent and respond to trafficking and other forms of irregular child movement.

Migration has negative impacts for the remaining household members, due to an increased dependency ratio. Caring practices are forced to change, with younger children having to assume more responsibility within the household after the migration of the older children. The vulnerability of children also increases when they are left behind by parents who have migrated and are left in situations that could lead to abuse or exploitation, due to the lack of parental care and reduced adult supervision.

FOOTNOTES

75 Ibid.
76 Ibid.
77 Ibid.
78 Ibid.
79 Save the Children Norway and CCORE, Characteristics of “Children on the Move 2007-09 (presentation - 26 August 2010)
3.2.7 Children’s and women’s life skills, knowledge and participation

Children are agents of their own protection and when equipped with knowledge and skills, can play a major role in minimising risk, reporting abuse and identifying solutions for protection concerns. Children must have knowledge about their rights and be encouraged to form views and express them. Life skills include problem solving and negotiation skills.

Passages in the current Constitution impedes the ability of children to freely participate due to the added proviso of 'by way of parental discipline' within the Bill of Rights, which restricts the unhindered realisation of their rights of freedom of expression, freedom of conscience and freedom of assembly and association. The CRC does not contain such a restriction. The application of this proviso is further complicated by the lack of definition of parental discipline, either in the Constitution itself or in any judicial pronouncement.

Children’s representatives, selected from a number of children’s organisations, were invited to contribute to the process of developing the periodic report to the Committee on the Rights of the Child. The statements by the children involved appreciate the opportunity to participate, but demonstrate that it was only through this process that they gained the knowledge about their rights and the laws of the country.81

The Ministry of Constitutional and Parliamentary Affairs has embarked on an ambitious initiative, in partnership with three non-governmental organisations, to build the capacity of children and their communities to participate in the constitutional review process that is currently underway.

Parliament offers the opportunity for peer-elected children to review and influence policy at the national level. Some district child protection committees include child representatives.

Participation must also fall within age-appropriate limits. Poverty continues to encourage many children to enter the paid or unpaid workforce earlier than would otherwise be appropriate. The Child Labour Report (2004) found that around 42 per cent of children are involved in economic activities, with around 16 per cent exceeding the acceptable limit of 3 hours a day. Ninety-nine per cent of children are providing free labour by performing domestic tasks for their family. While this statistic shows that boys and girls are involved in domestic tasks, it is accepted that girls carry a much heavier burden of domestic labour. The majority of children engaged in excessive child labour come from rural areas and are more likely to be out of school. About 87 per cent of children who were currently not in child labour attended school compared to 59 per cent of children in non-economic child labour.

3.2.8 Reporting, monitoring and oversight

Effective reporting, monitoring and oversight of the protective environment require the systematic collection of data together with a transparent analysis and reporting of child protection issues.

Assessing and analysing protection issues are fundamental to designing effective interventions and providing adequate support to children and women, and their families. Unfortunately, the true extent of protection issues is not accurately known due to a dearth of national, disaggregated data. Disaggregated data is vital to accurately reflect the varying impact of

FOOTNOTES

81 Second Periodic Report of the Republic of Zimbabwe to the Committee on the Rights of the Child, July 2009 (Draft not yet approved)

82 The definition of child labour in Zimbabwe has been adapted from the International Labour Organization’s (ILO) definition. The ILO defines economic child labour as when a child spends over one hour per week on any economic activity. Zimbabwe introduced three rather less stringent variation with three hours a day being permissible for economic activities (thereby allowing fifteen hours a week as opposed to the ILO’s one) and five hours a day for non-economic activities. Zimbabwe also allows children aged fifteen and above to participate in some form of work and children aged thirteen and above to work as apprentices.
Children's Participation in the Constitutional Process

What about us?

... We the children of Zimbabwe

Want to take part in the constitution-making process.

We are the majority, and the future of Zimbabwe, We should have a say like everyone else. We have the right to choose, Bonlat (Form 4, Amhlope, Bulawayo)

For the first time since the commencement of the constitution-making process, the Parliamentary Select Committee of the Inclusive Government of Zimbabwe has officially recognized the views, priorities and ideas of around 4,000 children in the official constitution-making process of Zimbabwe. UNICEF has supported the Ministry of Constitutional and Parliamentary Affairs to develop a child-friendly consultation methodology which has been implemented in 19 districts. Together with around 140 other children (ranging from junior parliamentarians to street children) these children participated in a 2 day summit in September 2010 in the nation's capital that consisted of outdoor games, small group discussions, plenaries and formal parliamentary debates. The event culminated in the presentation of a range of formal submissions to the Committee, including a score card which the children propose can be used to grade future drafts of their constitution. This is the first time that vulnerable children have been supported to come together with children from existing formal participation structures to participate in high profile legislative reform.

'Only adults means no country' (Children's book team, Matobo).

The current Constitution does not have explicit provisions committed to the realisation and protection of children's rights. The Bill of Rights in the Constitution is applicable to everyone, but there are no explicit rights for children which would address their exact needs and offer better protection, and in the case of corporal punishment, limits children's rights, compared to those of adults. The Bill of Rights guarantees civil and political rights, but it does not guarantee socio-economic and cultural rights, the issues most reflective of the day-to-day needs and lived realities of children.

Issues that have emerged from the consultations include:

- Protection from sexual abuse and violence - particularly against girls
- Education challenges: school fees, uniforms, examination fees, incentives for teachers, equal access and the impact of elections on access
- Birth registration
- Corporal punishment
- Child labour
- Inadequate opportunities for play and to be children
- Water and sanitation - access and quality
- Limited access to essential services - including health and welfare

'My hopes are: children having freedom of speech, being heard wherever they are and being treated fairly. In other words, recognition.' Karen, (Bulawayo)

Children have identified children with disabilities, those living with HIV and those out of school as having the least opportunity to participate or influence decision making. The participation of children in the Constitutional consultations provides a tremendous opportunity for them to articulate issues they consider important for inclusion in the new Constitution. It fosters national pride and an understanding of civic responsibility. It will also provide the Government with an example of good practice for child participation.

'Let the rights be ours. Give us the freedom, strength, opportunity and support to speak freely without fear of how we are affected by the way people treat us. If a child is given freedom of speech believe you me things will never be the same again'. Caroline, (Masvingo)
Care & Protection of Children and Women from Violence, Abuse and Exploitation

Participatory data collection by claim holders is one way to increase awareness about their rights and it is important for this data to be utilised by both the duty bearers and the claim holders. The rapidly changing socio-economic situation has further compounded this issue, as there is now little national, contemporary data on existing or emerging protection issues. More information is required on the causes of vulnerability and on community and family dynamics and coping mechanisms, to better inform efforts to support families to deal with recent and future shocks.

Many agencies are attempting to address the gap by establishing databases and commencing analyses to generate updated information. For example, the Victim Friendly Unit of the Zimbabwe Republic Police has been collecting data on child abuse cases, noting that 3,239 girls reported sexual violence to police in 2009. One of the strategies for the Victim Friendly Unit is to establish national baselines on juvenile offenders and child survivors, which will be disaggregated by age, gender and type of alleged offence or crime experienced. Other agency specific data on sexual abuse is being collected by Childline and the Victim Friendly Clinics which, collectively, are contributing to raising awareness of the issue and the generation of greater funding allocations to strengthen these critical services.

Disaggregated data is also essential for evidence-based policy development, resource allocation and to identify inequities that may remain hidden by national data sets. For example, while a majority of children require birth certificates to access education services (leading to a higher uptake of birth registration for older children); the 2009 MIMS data suggests that only 37 per cent of children receive this certificate before their 5th birthday. Similarly, the DHS in 2005-06 recorded that 74 per cent of children had been registered, but only 38 per cent had a birth certificate. This can lead to increased vulnerability for young children, limiting their legal protection and access to other basic services such as health and welfare.

Monitoring and oversight mechanisms are equally as important, and are critical for ‘invisible’ children or those with limited access to families or service providers. For example, at present there are 300 children detained in prisons. The number of children in alternative detention, such as training centres and probation hostels is unknown, as is the number of children in pre-trial detention. This lack of accurate statistics reflects an overall lack of oversight for children within the justice system. Some bodies established through legislation, such as the Child Welfare Council, are yet to be resourced and activated yet could play a key role in leveraging greater attention towards vulnerable children.

The conclusion to the state report to the Committee on the Rights of the Child acknowledges that the lack of up-to-date and disaggregated data has made it difficult to measure the effects of the policies that have been put in place to improve children’s rights, and commits the Government to rectify the situation by the next report.  

3.3 Conclusions and recommendations

The protection of girls, boys and women from violence and abuse requires a holistic, systems-based approach. In Zimbabwe, this requires that the legislative and regulatory frameworks that govern the welfare and justice systems are enforced and revised where necessary to encourage a stronger focus on excluded and invisible populations. Service delivery, led by government as the main duty bearer, must be scaled up and children, caregivers and child rights advocates must be supported with the knowledge, skills and resources to demand equitable and timely action.

More specifically, the following recommendations are made:

Domestication of international child rights commitments:
- Children’s rights and voices must be articulated at all stages of the Constitution-making process, and its implementation
- Ratification of the two Optional CRC protocols, including on Children and Armed Conflict and Child Trafficking
- Comprehensive review of existing legislation, compliance with CRC and CEDAW and the implementation of an operational plan to reach full compliance (including, but not limited to removing age and gender-based discrimination)
- Address age and gender discrimination laws, for example the age of consent and outlawing harmful traditional practices and corporal punishment against children

Protective policies and standards that focus the efforts of government and its partners on the most vulnerable:

FOOTNOTES
83 Second Periodic Report of the Republic of Zimbabwe to the Committee on the Rights of the Child, July 2009 (Draft not yet approved)
Care & Protection of Children and Women from Violence, Abuse and Exploitation

- Finalise the national GBV strategy to fully include the rights and needs of children and support subsequent implementation to increase effective, comprehensive services for survivors across the country
- Support the Government to develop and implement a costed, gender, HIV and child-sensitive social protection policy framework for the country that targets the poorest and most vulnerable families
- Develop a national strategy to address children on the move, including child trafficking, with regional support
- Ongoing support to Government to implement the Orphan Care Policy, with a specific focus on deinstitutionalisation and strict adherence to the National Residential Care Standards
- Building on the success of the Victim Friendly Courts, focus on a survivor centred, multi-sectoral and holistic system for supporting boys, girls and women to access justice
- Enhance advocacy and program alliances with a wide network of partners in the faith-based community, government, civil society sector and UN partners, to champion the protection of the most invisible children, including those at risk of sexual exploitation, child trafficking and child labour
- Increase access to birth certification for the most vulnerable children, particularly orphans, through removal of restrictive barriers
- Strengthen the capacity of duty bearers at all levels, and throughout the child protection system to identify and respond to violence, abuse and exploitation:

  **Knowledge and data**
  - Collect credible, reliable, disaggregated (by gender, region, age and other vulnerability dimensions) data on priority child protection and social protection issues indicating trends, prevalence and/or incidence to inform programming at the individual child level as well as in child protection system strengthening
  - Conduct further research on key ‘invisible’ issues such as sexual abuse

  **Skills and resources to facilitate access for vulnerable boys, girls and women**
  - Transfer knowledge, skills and resources for those responsible for the implementation of the regulatory frameworks - including Probation Officers (Children’s Act), teachers (classroom management) and police (Criminal Code)
  - Lobby for and support the revival of an effective cohort of national, provincial and district level para-professional social workers, with adequate resources to be able to manage child protection concerns in line with international and national good practice
  - Institutionalise child participation, particularly that of vulnerable children, within government and civil society in the design and implementation of all legislation, policy and programs that affect children
  - Introduce juvenile diversionary programs to minimise the use of custodial sentences for children in conflict with the law
  - Develop the knowledge and skills of traditional community and religious leaders to advocate for a review and revision of negative cultural and traditional practices
  - Increase protective services for children on the move, linked to specific legislation and policy guidance

**Oversight and monitoring**
- Support the development of oversight mechanisms for children in institutional care, detention and other vulnerable situations, and support the dissemination of information relating to the conditions of their care
- Resource legislated oversight bodies, such as the Child Welfare Council

**Support girls, boys and women to identify their protection rights and equip them with the knowledge, skills and resources to claim them:**
- Strengthen the capacity of families and develop village-level protection mechanisms to create safe and loving homes for the most marginalised, excluded and vulnerable children linked to broader social protection strategies and policies
- A sustained and coordinated behaviour change campaign to build knowledge and awareness of harmful beliefs and practices
- Develop and implement strategies to equip boys and girls, both in and out of school, with the knowledge of their rights and the skills to claim them
- Increase the reach and quality of programs aimed at protecting children on the move
- Create willingness and enthusiasm to participate in open discussion forums, supported by civil society engagement and more open reporting of sensitive issues in the media
4. Health and Nutrition of Children and Women

4.1 Historical and socio-economic context

Primary Health Care (PHC) was adopted in Zimbabwe in 1980 to deliver health care to the majority of the population through increased community access to health services. PHC was launched primarily to improve maternal, neonatal and child health (MNCH), and included high impact and cost effective interventions, such as comprehensive antenatal and postnatal care, an expanded programme of immunisation (EPI) as well as community level health promotion, child monitoring and surveillance through Village Health Workers (VHWs). Health care services were focused at the district and lower levels, so that preventive and curative MNCH services could be accessed simultaneously in a patient's single visit. By 1990, about 85 per cent of the population had access to basic health services. During the same period, child immunisation coverage increased from 25 to 80 per cent, and together with increased coverage of other child health interventions, resulted in an under five mortality rate which dropped by more than 20 per cent, from 104 per 1,000 live births to 81 per 1,000 live births.84

These achievements have not been sustained, and progress on key MNCH indicators have begun to reverse in recent times. In the past 20 years the maternal mortality ratio (MMR) increased from 390 per 100,000 live births in 1990, to 670 in 2000, to 790 in 2008.85 Along with only two other countries in the sub-Saharan region (Kenya and South Africa) the under five mortality rate has worsened in Zimbabwe, increasing from 79 per 1,000 live births in 1990 to 96 per 1,000 in 2009.86 Infant and under five mortality rates increased between 1990 and 2000, with rates levelling in 2000. Both are far from meeting the MDG targets. These trends are shown in Figure 17: Infant and under five mortality rates and MDG Targets. Further undermining trends in child health is the chronic malnutrition prevalence of 34 per cent among children aged 6-59 months.88

There are multiple factors which have contributed to the decline in the MNCH indicators over the past decade. The ongoing deterioration in the economy led to diminishing budgets available for health care, resulting in reduced provision at all levels. This system breakdown was characterized by a shortage of skilled professionals, eroded infrastructure, and lack of essential drugs and commodities. Concurrently, demand for services was undermined by the un-standardised application of user fees.

FOOTNOTES

84 UN Inter-agency Group for Child Mortality Estimation, 2010
85 Maternal, Newborn and Child Survival - Zimbabwe In Countdown to 2015 Decade Report
87 UNICEF, National Nutrition Survey, 2010
The challenges in the delivery of healthcare are further highlighted by the inequity in access to health services. According to DHS data, and as shown in Figure 18: Health coverage gap index in Zimbabwe 1994 to 2005, the overall health coverage gap narrowed between 1994 and 1999 but subsequently widened between 1999 and 2005, reversing earlier gains. This unmet need in health services for the poorest quintiles is twice as high as for the wealthiest quintile. Differences also exist between religious groups, as shown in Figure 19: Role of religion and access to health services. The Apostolic sect community, which accounts for up to one third of the population, has the lowest usage rate of health services in terms of immunisation and maternal health services. The population practicing traditional religions also fare worse than the average population.

4.2 Legal, regulatory and policy framework

Zimbabwe's solid legislative and policy environment reflects the Government's commitment to children's and women's welfare. The health sector is guided by 'The National Health Strategy for Zimbabwe (2009-2013) - Equity and Quality in Health: A People's Right'. The national strategy ensures protection of the poor and vulnerable through exemption of user fees, maintains the PHC approach, integrates preventive and curative services through a 'supermarket' approach, and promotes the use of VHWs to strengthen the public health capacity of communities. However, some policy gaps, such as the National Nutrition Policy and Infant and Young Child Feeding Guidelines require urgent finalisation.

The Government is signatory to a number of international instruments that support delivery of equitable health services, including:

**Figure 17: Infant and Under 5 Mortality Rates 1990 to 2008 and MDG Targets - Zimbabwe**

*Source: Inter-agency Group for Child Mortality Estimation (IGME), 2009*

**Figure 18: Health coverage gap index in Zimbabwe 1994 to 2005**

*Source: Countdown Equity Analysis Group (2008); Mind the gap: equity and trends in coverage of maternal, newborn, and child health services in 54 Countdown countries. Lancet, 2008; 371: 1259-67*

---

**FOOTNOTES**


**89** The coverage gap index is defined as the percentage of people not receiving a specific intervention of the population who require that intervention/ service. This index captures coverage in four intervention areas: family planning, maternal and newborn care, immunisation, and treatment of sick children.
The UN Convention for the Rights of the Child (1989)
The Millennium Declaration (2000)
The Abuja Declaration (2000)
The Ouagadougou Declaration (2008) on Primary Health Care and Health Systems in Africa

In addition to the National Health Strategy for Zimbabwe (2009-2013), the Government has adopted a wide range of legislation, policies and strategies that promote children and women’s health and welfare including:

- Public Health Act
- Children’s Act
- Maternity Act
- Comprehensive Multi-year Plans for EPI (2009-2013)
- Health Sector Investment Case (2010-2012)
- National Gender Policy
- Nutrition and HIV Strategy (draft, 2010-2014)
- Infant and Young Child Feeding Policy (draft, 2010)
- Code for Marketing Breast Milk Substitutes

**FOOTNOTES**

90 MoHCW, National Child Survival Strategy for Zimbabwe 2010-2015, June 2010
91 Planning for the 2011-2015 ZNASP is underway, supported by a 'Modes of Transmission' study.
4.3 Challenges within the health system

Zimbabwe currently spends USD 9 per capita on health, less than half of the USD 34 recommended by the Ouagadougou Declaration. The government has recently endorsed a Health Sector Investment Case which quantifies levels of investment required to impact on progress towards attainment of the health-related MDGs.

In 2009, the Government allocated 12 per cent of the national budget to health; however, the MoHCW received only approximately 30 per cent of what was allocated. Salaries for health workers represented 92 per cent of expenditures.

The Health Sector Investment Case (2010-2012)
Accelerating Progress Towards MDGs

The Investment Case aims to revitalize the health sector, identify high impact priority interventions, and mobilise additional resources to scale up progress towards attainment of the MDGs. It identifies the health system bottlenecks to be overcome, the desired coverage, and the cost of delivering vital services. The Investment Case proposes three investment options (modest, medium, and comprehensive) and for each option presents a) priority high impact interventions and targets; b) estimated morbidity and mortality reduction; and c) the budget and financing gap based on actual and anticipated government funding, taking into account assumptions on external funding. Under the most ambitious scenario, USD 700 million is required over 3 years, or an additional USD 19 per capita, to achieve a reduction of under-five and maternal mortality of 38 per cent and 17 per cent, respectively. Sizeable resource mobilisation, investment and efficiency measures are therefore urgently required.

Loss of human resources in the health sector has had a significantly detrimental impact on the availability of services, particularly in rural areas. Vacancy levels are as high as 89 per cent for midwives, 64 per cent for government medical officers and 49 per cent for nursing tutors. Although demand for midwifery training is high, only 13 of the country's 20 midwifery schools are currently functioning, with plans and funding now in place to revive all 20 schools. In an effort to address high vacancy levels, MoHCW has trained over 4000 Primary Care Nurses (PCNs) since 2004. PCNs are deployed to rural health centres following one-year training, as opposed to the three-year training received by Registered Nurses (RNs). A donor-funded Health Retention Scheme has assisted in retaining some staff, but a long-term solution for retaining qualified health staff is urgently required. To compensate for staff shortages, the Government has also introduced 'task sharing,' allowing health workers to perform new tasks. For example, Primary Counsellors were recently approved to provide HIV testing and counselling, and MoHCW is advocating for nurses to initiate anti-retroviral treatment (ART).

Following independence, Zimbabwe did not charge user fees in public facilities, and a social welfare system exempted the most poor from paying. However, as part of Structural Adjustment user fees were introduced into the public health system in 1991. Since then, the official policy has been to exempt pregnant women, the elderly, and children under five from fees. Lack of supervision and the decentralisation of health services that allows local authorities to set fees for municipal facilities without central government oversight, have resulted in the continuation of user fees for maternal and child health services. As a result, rates and collection systems vary across the country and serve as a significant barrier to women and children accessing health services. For example, fees are charged for pregnant women to allow delivery in a health facility, and for additional requirements, ranging from routine commodities to life-saving supplies, such as units of blood in the case of haemorrhage.

The health infrastructure has deteriorated significantly, often with no piped water, electricity or working toilets. This poses increased threats of infection due to

FOOTNOTES

92 WHO Zimbabwe, 2010
93 Ougadougou Declaration on Primary Health Care and Health Systems in Africa, 2008
94 MoF, Budget Estimates for the Year Ending 31 December 2010
96 Zimbabwe Association of Doctors for Human Rights, 2009
challenges facilities have in maintaining infection control standards. During the past decade, shortages of essential drugs and commodities were also a problem due to the lack of hard currency. Initiated in 2009, the Vital Medicines Support Program (VMSP), a coordinated donor response, addressed critical shortages in 1,400 health centres and hospitals across the country. Key findings from routine audits show that the number of health facilities with at least 50 per cent of selected essential drugs in stock increased significantly from 44 per cent in 2009 to 91 per cent in 2010, as shown in Figure 20. Access to other supplies also increased and led to overall increases in the delivery of full maternity services and cholera response capability.97

4.4 HIV and AIDS

Zimbabwe has long been at the epicentre of the HIV epidemic. The estimated HIV prevalence among adults 15-49 years is 14.3 per cent.98 Women face a higher risk of infection at younger ages: 7.45 per cent of women 15-24 years are HIV positive, compared to 3.54 per cent of their male peers.99 A number of factors have been cited as contributing to young people’s, and particularly young women’s, risk to HIV:

- Among young women and men, aged 15-19, only 41 per cent and 44 per cent (respectively) have a comprehensive knowledge about HIV transmission (ZDHS 2005/6). According to the 2009 MIMS, 53 per cent of women 15-24 had comprehensive knowledge.
- Condom use during high risk sex varies markedly between young women and men (15-24 years) - 42 per cent of young women reported using a condom the last time they had sex with a high-risk partner, compared with 68 per cent of young men (ZDHS 2005/6).
- Low uptake of HIV testing among men and women in the 18-19 year age range (27 per cent for women and 16 per cent for men)(MoHCW 2007/8).

HIV is a major determinant of child and maternal health in Zimbabwe, and is most likely one major factor responsible for the rise in both child and maternal mortality since the early 1990s. HIV-related causes contribute indirectly to 26 per cent of maternal deaths and directly to 21 per cent of under 5 mortality.100

As shown in Figure 21: Trends in adult HIV prevalence 1981 to 2007, there has been a significant decline in HIV prevalence since the peak of the pandemic in 1997. Intensive data analysis shows that the decline in HIV prevalence was driven by a combination of falling HIV incidence and high mortality.102 A combination of behaviour change programmes, as well as personal experience with death of friends and relatives, appears to have contributed to the decline at different levels. Change in behaviours and norms occurred, particularly among men, which led to a reduction in multiple partnerships and commercial sex, supported by sustained condom use.

More recently, preliminary results of the 2010 Modes of Transmission study found that the bulk of new HIV infections (approximately 56 per cent) are occurring among individuals in low-risk heterosexual relationships that are characterized by discordancy. People involved in casual sexual relationships (more than 1 partner a year) and their partners contribute about 24 per cent of new HIV cases while sex workers and their clients contribute to approximately 14 per cent.

Figure 20: Trends in Availability of Selected Essential Drugs in Health Facilities, Zimbabwe

Source: MoHCW, Vital Medicines and Health Service Survey, Rounds 1 to 5

<table>
<thead>
<tr>
<th>Period</th>
<th>Percentage of Health Facilities with 50% Available</th>
<th>Percentage of Health Facilities with 70% Available</th>
<th>Percentage of Health Facilities with Complete Stock Out</th>
</tr>
</thead>
<tbody>
<tr>
<td>Round 1 (Jan-Mar 09)</td>
<td>44.2%</td>
<td>20.5%</td>
<td>1.5%</td>
</tr>
<tr>
<td>Round 2 (Apr-Jun 09)</td>
<td>74.8%</td>
<td>63.7%</td>
<td>3.8%</td>
</tr>
<tr>
<td>Round 3 (Jul-Sept 09)</td>
<td>91.4%</td>
<td>85.3%</td>
<td>2.4%</td>
</tr>
<tr>
<td>Round 4 (Oct-Dec 09)</td>
<td>93.8%</td>
<td>94.8%</td>
<td>0%</td>
</tr>
</tbody>
</table>

FOOTNOTES
98 MoHCW, National Estimates of HIV/AIDS, 2010
99 Ibid.
100 Munjanja S, Maternal and Perinatal Mortality Study 2007, 2007
101 Gregson S et al, HIV infection and reproductive health in teenage women orphaned or made vulnerable from by AIDS in Zimbabwe, 2005
102 Ibid.

The Prevention of Mother-to-Child Transmission (PMTCT) program began as a three-site pilot in 1999, and was rolled out in 2002, with full integration into antenatal care services. PMTCT services are currently offered in over 1,560 health facilities. Of these, 940 facilities are comprehensive PMTCT sites (that is, they offer both HIV testing and antiretrovirals (ARVs), while the remaining 620 are basic PMTCT sites (that is, they have ARVs but do not do on-site HIV testing.) Two hundred sites offer the more efficacious PMTCT prophylaxis regimen (MER), while the remainder still only give single-dose Nevirapine.

In 2009, 59 per cent of pregnant women received ARVs to reduce risk of vertical transmission; compared to only 46 per cent of HIV exposed infants who received prophylactic ARVs. Consequently, an estimated 10,000 infected infants (out of an estimated 50,069 HIV exposed births) were expected in 2009. In addition, only 54 per cent of HIV exposed infants seen in the programme received cotrimoxazole, a simple antibiotic that can save HIV positive children's lives.

A key goal of the Zimbabwe National HIV/AIDS Strategic Plan (2006-2010) is universal access to care and treatment. As of June 2010, 282,916 HIV infected patients (public and private) were on ART out of the 593,168 who need them (taking into account new WHO eligibility guidelines). Of those, about 24,441 (10 per cent) were children below 15 years, out of the 89,490 children in need. Of those, only 680 (out of an estimated 7,000) were less than 18 months, reflecting a significant gap in early infant diagnosis and treatment.

Diagnosing and providing care to HIV exposed infants is critical to reducing infant and child mortality. In 2009, only 13 per cent of HIV exposed infants were tested for HIV. National plans are underway to dramatically increase this figure; 42 per cent of HIV exposed infants are expected to be tested for HIV by the end of 2010, and those diagnosed as HIV positive will be started on treatment.

The treatment coverage gap will widen further as the country adopts the 2010 WHO Anti-retroviral Treatment (ART) Guidelines which increases the number of eligible adults and children. In addition, HIV positive pregnant women face high risks of maternal morbidity and mortality, and those who are treatment eligible (CD4 counts of less than 350) urgently require ART for their own health. By the end of 2010, approximately 60 per cent of HIV infected pregnant women are expected to be initiated on ART for their own health.

Despite positive achievements in HIV prevention and
treatment, HIV prevalence and mortality remains unacceptably high. The impact of HIV is manifested across all geographic areas and population groups within the country, playing a major underlying role in morbidity and mortality. The impact is particularly felt by women and children, exacerbated by poverty, poor maternal health, poor nutrition and gender inequalities.

4.5 Providing a continuum of services in maternal and child health

The Countdown to 2015 Decade Report tracks coverage along a continuum of care from pre-pregnancy and childbirth through childhood up to age five, highlighting missed opportunities for the delivery of lifesaving interventions. The first dimension of the continuum is ‘time’; this includes pre-pregnancy, throughout the pregnancy, childbirth and the early days and years of life. The second dimension is ‘place’; this links the various scales and networked care giving between households, communities and health facilities to reduce maternal, new-born and child deaths.

Interventions within the continuum of care are essential for the health and wellbeing of mothers and children, however, with the exception of antenatal visits, Zimbabwe is providing less than adequate care along this continuum.

4.5.1 Maternal health

Effective and timely antenatal care (ANC) is essential to protect the health of both mother and child. ANC in Zimbabwe for a single visit has remained high in recent years. Nationally, 93 per cent of women aged 15-49 years received antenatal care during pregnancy at least once.105 ANC at four visits, however, has recently declined markedly to 68 per cent. Generally, there are no major differences of ANC coverage between rural and urban areas or depending on the age of the mother, education of the mother and wealth status.

Trends in maternal mortality are shown in Figure 22 Maternal Mortality (per 100,000 live births) adjusted figure 1990 to 2010. Maternal mortality is significantly higher at 790 deaths per 100,000 live births (2008) than it was in 1990, at 390 deaths.106 In part this is due to the significant impact of HIV on maternal mortality. In addition, the ‘three delays’ contributed to 72.8 per cent of the deaths. The first (delay in recognising a problem and deciding to seek care) contributed to 56 per cent of maternal death, the second (delay in reaching a facility after the decision to seek care) to 5.3 per cent and the third (delay in getting effective treatment at the facility) to 11 per cent. Significantly, the majority of deaths, 63 per cent, occurred in the post-partum period, emphasising the importance of following up women in the first few days after giving birth.108 Post-natal care coverage currently stands at only 30 per cent.

According to the Maternal and Perinatal Mortality Study (2007), the primary causes of maternal deaths were as follows: 19.6 per cent due to post-partum haemorrhage, eclampsia/ pre-eclampsia accounted for 17.9 per cent, 10.6 per cent due to infections, 7.8 per cent due to abortion complications, and 7.8 per cent due to malaria.

FOOTNOTES

104 Countdown to 2015 Decade Report, 2010
105 CSO/ZimStats, Multiple Indicator Monitoring Survey (MIMS) Preliminary Report Zimbabwe, 2009
106 Countdown to 2015 Decade Report, 2010
108 Ibid.
109 Ibid.
An important finding from the same study is that AIDS defining conditions contributed indirectly to 26 percent of maternal deaths.

The risk of maternal death increases significantly with deliveries occurring at home, operative delivery, delivery by a non-skilled person and membership in the Apostolic church.109 Although all district hospitals and rural health centres should offer skilled birth attendance and essential maternal and newborn care, this is not occurring in practice. PCNs receive basic training in essential maternal and newborn care, and have recently received refresher trainings. However, systematic supervision is weak and both PCNs and prospective clients lack confidence in the PCNs delivery skills. As a result, women are referred to district hospitals, which can increase the delay in receiving the necessary skilled care.

Access to care at delivery is limited due to user fees, low coverage of obstetric care in rural areas, and difficulty in getting to services in rural areas. The provision of maternity waiting homes has in the past helped women get to facilities in good time, but there is currently very limited availability. In addition, when women are aware of the poor quality of services, they choose to travel to facilities that are far away or use the services of traditional birth attendants.110 The poorest quintiles (quintiles one to three) appear to be most affected with lower rates of skilled birth attendance, and a 20 per cent decline since 1994. This disparity is illustrated in Figure 23: Skilled birth attendance by wealth quintile in Zimbabwe, 1994 to 2009. Rural to urban disparity also worsened during this period with the rural population experiencing marked declines in birth attendance by a skilled attendant.

An important determinant of women’s health is awareness and availability of contraception to reduce exposure to the risks of pregnancy and enable effective child spacing, both of which protect the mother’s health as well as reduce the risks of early child deaths. In 2009, 65 per cent of currently married or in-union women, aged 15-49, were using a modern family planning method.111 Contraceptive use is high but there is still a 13 per cent unmet need for family planning. In addition, contraception use is lower in rural (63 per cent) than in urban areas (69 per cent) and higher levels of usage are associated with education and wealth.
4.5.2 Direct causes of child mortality

Neonatal causes are the leading cause of death in children under five years of age (see Figure 24). In the Study of Maternal and Perinatal Mortality (2007), nearly half of neonatal deaths (49.1 per cent) were caused by preterm birth, followed by intra-partum asphyxia (20.3 per cent), infection (18 per cent) and multiple pregnancy (6 per cent)(see Figure 25). The extent of neonatal vulnerability is demonstrated by the 49.4 per cent of infants who died in the first 24 hours of life. Further, more than two thirds (68.6 per cent) died in the first 72 hours and by the end of seven days, 82.6 per cent of the deaths had occurred. Most of these deaths are preventable through interventions that address unsafe delivery environments, delays in seeking skilled health care, poor antenatal surveillance and poor post-natal care. There are high impact and cost effective preventive and curative interventions that can address the major killers of newborns such as, provision of essential newborn care immediately after birth, keeping newborns warm, cord care, resuscitation of asphyxiated newborns, early initiation and exclusive breast feeding, Kangaroo-mother care and early identification and prompt treatment of newborn infection.

After neonatal causes and HIV, pneumonia is the third leading cause of death of under 5 mortality, contributing to 14 per cent of deaths. In 2009, only 16 per cent of all children with suspected pneumonia received antibiotics. Children in urban areas were more likely to have received antibiotics than those in rural areas. More emphasis on early diagnosis and timely treatment with antibiotics is needed to prevent this large proportion of deaths. The MoHCW is revising the current Integrated Management of Newborn and Childhood Illness (IMNCI) guidelines prior to training all health workers in primary health care centres.

Diarrhoea is the fourth leading cause of mortality among children under five in Zimbabwe, contributing 9 per cent of childhood deaths. Approximately 80 per cent of the diarrhoeal deaths have been attributed to poor hygiene, inadequate sanitation, and lack of safe drinking water. Diarrhoea is relatively easily treated with oral re-hydration therapy. Salt and sugar solution is promoted throughout Zimbabwe but a recent community based survey indicates that although there was widespread knowledge of the solution as an effective treatment, only 50 per cent knew the correct amount of salt to use and 69 per cent knew the correct amount of sugar. Reinvigorated health promotion campaigns need to emphasize correct oral re-hydration therapy, while the underlying determinants of diarrhoea are addressed.

Zimbabwe’s expanded programme on immunisation was highly successful from independence until 2000, when coverage began to decline and only started to recover in 2009. Measles previously contributed to less than 1 per cent of child mortality. However, outbreaks of measles in 2009 and 2010 resulted in measles becoming the fifth highest cause of death in children under five. Pockets of unimmunized children have been identified amongst certain religious groups whose members are reluctant to seek preventative or curative

**Figure 24: Causes of Under-5 Mortality in Zimbabwe**

*Source: National Child Survival Strategy 2010*

**Figure 25: Causes of Neonatal Deaths**

*Source: Munjanja S, Maternal and Perinatal Mortality Study 2007*
Health services. In 2010, 11,533 suspected cases of measles were reported and 642 confirmed, with 526 fatalities, most of whom were children. An assessment of the 2010 National Immunization Days demonstrated that Zimbabwe had managed to attain high coverage and effectively mitigate further outbreaks. Nonetheless, continuous effort is needed to improve and sustain achievement in immunisation.

Malaria is endemic in 45 of the 62 districts in Zimbabwe, and contributes to 3 per cent of under five mortality. In the two weeks preceding the 2009 MIMS survey, 8 per cent of children under five had experienced fever, and of these, only 14 per cent had received any appropriate anti-malarial drug within 24 hours of onset of symptoms. In a community-based survey, two-thirds of households reported that malaria drugs were the most commonly available drugs in local clinics, suggesting a gap between presentation of symptoms and appropriate treatment. There has
been increased use of insecticide treated nets (ITNs) as reported in MIMS 2009, with 17 per cent for children under five sleeping under an ITN, an increase from the 2 per cent recorded in the 2005/6 DHS.

Zimbabwe’s new Child Survival Strategy recommends intermittent prophylactic anti-malaria treatment and ITNs in malaria endemic areas for pregnant women, earlier recognition of fever, and strengthened training of health workers and Village Health Workers in rapid diagnosis and treatment.

4.5.3 Maternal and child nutrition

4.5.3.1 Child nutritional status

Today, one in every three Zimbabwean children suffers from chronic malnutrition (stunting). Globally, maternal and child undernutrition contributes to 35 per cent of all child deaths and 11 per cent of the global disease burden. Applying these estimates to Zimbabwe, undernutrition is likely to contribute to more than 12,000 child deaths each year.
The undernourished children that survive suffer life-long consequences; they are more susceptible to disease, and are likely to have poorer educational outcomes, poorer birth outcomes, and reduced economic activity into adulthood. Undernourished young children who gain weight rapidly later in childhood and into adolescence are at increased risk of chronic disease conditions such as cardiovascular disease later in life. 117

While rates of chronic malnutrition in Zimbabwe are moderate relative to other sub-Saharan African countries, they have been rising at alarming rates over the past 15 years. Rates of chronic malnutrition have increased by nearly 40 per cent since 1994 and at present trends, will reach critical levels within the next decade. Even more concerning are the large disparities in rates of malnutrition between districts, wealth groups, boys and girls, and children residing in rural and urban areas.

Rates of chronic malnutrition range from a low of 21 per cent in Beitbridge District,118 to a high of 47 per cent in Mutare District.119 As shown in Figure 26: Prevalence of Stunting in children aged 6 - 59 months, by district, nearly one quarter of Zimbabwe’s districts have rates of malnutrition categorised as “high” according to global thresholds.120

Furthermore, rates of chronic malnutrition are considerably higher among the poorest quintile of the population (40 per cent) than the wealthiest quintile (25 per cent).121 Wealth and malnutrition in Zimbabwe appear to have an inverse relationship; the poorer the population, the higher the malnutrition. It is interesting to note, however, that even the wealthiest quintile have unacceptably high rates of malnutrition. As shown in Figure 27 Rates of moderate stunting by wealth quintile and year of data collection, these trends are consistent across time.

Boys are significantly more likely to be malnourished than girls (38 and 30 per cent respectively), and children residing in rural areas are significantly more likely to be malnourished than children residing in urban areas (35 and 27 per cent).122

While rates of chronic malnutrition have risen steadily over the past decade, rates of acute malnutrition have remained stable or declined over time. At 2.4 per cent123, the rate of global acute malnutrition (GAM) represents a limited public health threat. This figure, however, obscures disparities between age groups, as well as a relatively high ratio of severe malnutrition to moderate malnutrition. Rates of GAM in children 6 to 24 months of age (3.5 per cent) are nearly twice as high as those for children 24 to 59 months of age (1.9 per cent), and nearly 10,000 young children (0.6 per cent) at any given time suffer from severe acute malnutrition,124 a strong predictor of mortality.125 A
sudden deterioration in the food security or health situation in Zimbabwe could trigger a rapid deterioration in rates of acute malnutrition. In 2008, rates of GAM were estimated at 5.6 per cent, just shy of the national emergency threshold of 7 per cent.126

Micronutrient malnutrition is often referred to as the silent killer; it is less obvious than stunting or acute malnutrition but its impact is equally devastating. In Zimbabwe, more than half of children 6-59 months (58 per cent) and nearly half of the pregnant women in Zimbabwe (47 per cent) suffer from anaemia.127 Rates of anaemia in Zimbabwe are considered a severe public health threat according to global thresholds.

There is no current information on rates of Vitamin A deficiency in Zimbabwe. In 1999, 36 per cent of children between 1 and 6 years were Vitamin A deficient, as were 7 per cent of women of reproductive age.128 At 1999 levels, Vitamin A deficiency would be considered a problem of public health significance according to global thresholds. On a positive note, according to global thresholds, Zimbabwe has achieved universal salt iodisation (USI)129 and sustainably eliminated Iodine Deficiency Disorders (IDD).130

Consistent with global experience, malnutrition in Zimbabwe begins in-utero and peaks at 24 months of age with little recovery thereafter.131 See Figure 28: Mean Z-Score for stunting, wasting, and underweight, by age in months.

One in every 10 children (10 per cent) in Zimbabwe is born with a low weight at birth (<2500g).132 Birth weight in Zimbabwe is inversely related to childhood stunting. In addition, the prevalence of low birthweight is higher in children born to mothers with a low body mass index (BMI) than in mothers with a high BMI.133 Globally evidence suggests that maternal nutrition and health care during pregnancy are the strongest determinants of foetal growth and birth weight.

Maternal nutrition

In Zimbabwe, an estimated 9 per cent of non-pregnant women are considered thin (BMI <18.5), and 2 per cent are considered very thin (BMI <17).134 Women in rural areas are more likely to be thin (10.8 per cent) than women in urban areas (6.8 per cent), and women in the lowest wealth quintile are more likely to be thin (12.9 per cent) than women in the highest wealth quintile (5.8 per cent).135 As with child malnutrition, there appears to be a dose/response relationship between wealth quintile and maternal nutritional status.

An estimated 25 per cent of non-pregnant women in Zimbabwe are overweight (BMI >25). Women in urban areas are more likely to be overweight (35 per cent) than women in rural areas (18 per cent), and women in the highest wealth quintile are more likely to be overweight (39 per cent) than women in the lowest wealth quintile (13 per cent).136 The prevalence of overweight in women in Zimbabwe may represent an emerging public health threat. There are no data on the nutritional status of pregnant women due to methodological constraints.

Causes of maternal and child malnutrition

Maternal and child undernutrition result from an interaction between poor dietary intake and disease. These determinants are driven by food insecurity, sub-

### Footnotes

127 Defined as greater than 90%, WHO, UNICEF, ICCIDD, Assessment of IDD and Monitoring their Elimination, 2001
128 Defined as median iodine levels >100 ug/l, <20% below 50 ug/l, and >90% HH using iodized salt. WHO, UNICEF, ICCIDD, Assessment of IDD and Monitoring their Elimination, 2001
129 Zimbabwe National Nutrition Survey, Food and Nutrition Council, 2010
130 DHS, 2006
131 Mbuya et al., Biological, Social, and Behavioral Determinants of Low Birth Weight and Stunting Among Infants and Young Children in Zimbabwe, 2010
132 Zimbabwe Demographic Health Survey, 2006
133 Ibid.
134 Ibid.
135 Ibid.
optimal care practices and an unhealthy household environment and lack of health services.

**Diet:** In Zimbabwe, just 30 per cent of children 6 to 23 months receive the globally recommended number of food groups for their age (quality), and just 28 per cent receive solid, semisolid, or soft foods the minimum number of times recommended for their age (quantity). Less than 1 in 10 children (8 per cent) receive the globally defined minimum acceptable diet for their age. Diet and disease are intimately related - a sick child is likely to have reduced appetite, higher caloric requirements, and difficulty absorbing nutrients, and a poorly nourished child is more susceptible to disease. While malnutrition can result from either poor dietary intake or disease, it often results from a combination of the two.

**Disease:** Illnesses of most concern for nutrition in Zimbabwe are consistent with those of greatest concern for child survival: diarrhoea, acute respiratory infections, and HIV. Children with diarrhoea and fever in the two weeks preceding the 2010 National Nutrition Survey were significantly more likely to be acutely malnourished than their non-sick counterparts. While there is limited data regarding the relationship between HIV and nutrition in Zimbabwe, global experience has established a strong correlation. Estimates in Zimbabwe suggest that up to 70 per cent of all admissions for treatment of Severe Acute Malnutrition (SAM) may be HIV positive.

**Food insecurity:** The food security situation in

---

**Figure 29: Seasonal food security timeline**

*Source: Fewsnet, 2010*

<table>
<thead>
<tr>
<th>Peak food insecurity</th>
<th>Hunger Season</th>
<th>Food security &amp; vulnerability assessments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cereal prices increase sharply &amp; early</td>
<td>Urban food security &amp; nutrition assessments in LE, MW, SZ, ZA,ZW</td>
<td></td>
</tr>
<tr>
<td>Jul 2007 Aug Sep Oct Nov Dec Jan 2008 Feb Mar Apr May Jun</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ZA, ZW: wheat harvest</td>
<td>Land prep</td>
<td>Planting</td>
</tr>
<tr>
<td>MZ: 2nd harvest</td>
<td>MW: winter harvest</td>
<td></td>
</tr>
<tr>
<td>Labour demand peaks</td>
<td>Labour demand peaks</td>
<td></td>
</tr>
<tr>
<td>Seasonal Rains</td>
<td>Green harvest</td>
<td>Main season harvest</td>
</tr>
</tbody>
</table>

---

**FOOTNOTES**

139 Semba and Gray, Human Immunodeficiency Virus Infection, In Nutrition and Health in Developing Countries, Humana Press, 2001
140 As reported by NGO implementing partners
141 Zimbabwe National Nutrition Survey, Food and Nutrition Council, 2010
142 FAO and WFP, FAO and WFP Crop and Food Security Assessment Mission to Zimbabwe, 2010
Health and Nutrition of Children and Women

Zimbabwe has improved markedly since 2009, but remains a significant concern. Today, approximately one third (33 per cent) of Zimbabwean children reside in households with poor to borderline food consumption scores, and more than one third (33 per cent) reside in households that experienced a food deficit of more than five months in the preceding year. It is estimated that 30 per cent of rural households will have poor to borderline food consumption during the 2011 season, and that 1.6 million people (15 per cent of the population) will require food assistance. Zimbabwe remains highly vulnerable to natural and man-made events that could have a dramatic impact on either availability or access to food. In 2008, poor agricultural production and record inflation led to nearly half the population becoming dependent upon food assistance. Food insecurity, similar to disease prevalence, fluctuates throughout the year. Seasonal fluctuations, as outlined in Figure 29: Seasonal food security timeline, have important implications for the prevalence of acute malnutrition which tends to peak during the height of the "hunger season."

Sub-optimal care practices: Seventy- five per cent of Zimbabwean children are breastfed within one hour of birth, and more than 77 per cent are breastfed until their first birthday. However, only six per cent of Zimbabwean children under the age of 6 months are exclusively breastfed. Nearly one in three children (27 per cent) receive soft, semi-solid, or solid foods before the age of 3 months, and more than half (52 per cent) receive soft, semi-solid, or solid foods before the age of 6 months. Mixed feeding, as evidenced by high rates of continued breastfeeding, low rates of exclusive breastfeeding, and early introduction of complementary foods, is common in Zimbabwe. Globally, mixed feeding is associated with more clinic visits (morbidity) and an increased risk of mother to child transmission of HIV. Less than one in ten children (8 per cent) receive a minimum acceptable diet, and very few regularly receive eggs, meat, legumes, or fruits and vegetables; see Figure 30: Percentage of children consuming specified foods, by age grouping. Further, only one in three children experiencing diarrhoea (35 per cent) receives Oral Rehydration Therapy or increased fluids and continued feeding during illness.

Environment and Health Services: Children living in urban areas are significantly more likely to be in households using adequate water and sanitation facilities than children living in rural areas. Coverage of improved water and sanitation in rural areas is 68 per cent (water) and 50 per cent (sanitation), compared to urban areas with 98 per cent (water) and 97 per cent (sanitation.) Poor sanitation and hygiene are associated with increased rates of diarrhoea, and diarrhoea is related to growth faltering. Research in Zimbabwe suggests that poor hygiene and sanitation may also be associated

---

**FOOTNOTES**

140 Zimbabwe National Nutrition Survey, Food and Nutrition Council, 2010
141 Food and Nutrition Council, Zimbabwe National Nutrition Survey, 2010
142 CSO/ZimStats, Multiple Indicator Monitoring Survey (MIMS) Preliminary Report Zimbabwe, 2009
143 Food and Nutrition Council, Zimbabwe National Nutrition Survey, 2010
144 Lanata and Black, Diarrheal Diseases, in Nutrition and Disease in Developing Countries, Humana Press, 2001
146 Food and Nutrition Council, Zimbabwe National Nutrition Survey, 2010
with undernutrition independent of diarrhoea through the mediating factor of tropical enteropathy. Should this hypothesis be true, poor hygiene and sanitation may have far greater impact on nutritional outcomes than previously estimated. In Zimbabwe, children residing in households using sub-optimal water and sanitation facilities are significantly more likely to be malnourished than those using improved services.

In the absence of a quality diet, supplementation has proven an effective means of delivering key micronutrients. While coverage of Vitamin A supplementation in children in Zimbabwe is relatively high at 85 per cent, coverage of maternal Vitamin A and iron supplementation are extremely low at 28 and 25 per cent respectively. Child supplementation is often delivered through campaigns, while maternal supplementation is typically delivered through antenatal services suggesting that recurrent service delivery may be more problematic than campaign style delivery of micronutrient supplements.

Table 3: Addressing malnutrition in Zimbabwe

<table>
<thead>
<tr>
<th>Interventions with proven effectiveness</th>
<th>Coverage in Zimbabwe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal iron/folate supplementation</td>
<td>28%</td>
</tr>
<tr>
<td>Maternal multiple micronutrient supplementation</td>
<td>0%</td>
</tr>
<tr>
<td>Maternal iodine (fortification)</td>
<td>&gt;90%</td>
</tr>
<tr>
<td>Maternal calcium supplementation</td>
<td>N/A</td>
</tr>
<tr>
<td>Reduced tobacco consumption</td>
<td>N/A</td>
</tr>
<tr>
<td>Maternal energy/protein supplementation</td>
<td>0%</td>
</tr>
<tr>
<td>Maternal iodine supplementation</td>
<td>N/A</td>
</tr>
<tr>
<td>Maternal de-worming (pregnancy)</td>
<td>0%</td>
</tr>
<tr>
<td>IPT Malaria</td>
<td>14%</td>
</tr>
<tr>
<td>ITN</td>
<td>27%</td>
</tr>
<tr>
<td>Immediate Breastfeeding</td>
<td>75%</td>
</tr>
<tr>
<td>Exclusive Breastfeeding</td>
<td>6%</td>
</tr>
<tr>
<td>Neonatal Vitamin A Supplementation</td>
<td>0%</td>
</tr>
<tr>
<td>Delayed cord clamping (iron)</td>
<td>N/A</td>
</tr>
<tr>
<td>Exclusive breastfeeding</td>
<td>6%</td>
</tr>
<tr>
<td>Continued breastfeeding through 1 to 2 years (dependant on HIV status)</td>
<td>77% and 20% respectively</td>
</tr>
<tr>
<td>Timely introduction of appropriate complementary foods</td>
<td>8% (MAD)</td>
</tr>
<tr>
<td>Zinc supplementation</td>
<td>0%</td>
</tr>
<tr>
<td>Zinc in the management of diarrhoea</td>
<td>N/A (&lt;18%)</td>
</tr>
<tr>
<td>Vitamin A supplementation (fortification)</td>
<td>85%</td>
</tr>
<tr>
<td>Salt iodisation</td>
<td>&gt;90%</td>
</tr>
<tr>
<td>Promotion of handwashing and hygiene interventions</td>
<td>N/A and 55% respectively</td>
</tr>
<tr>
<td>Treatment of acute malnutrition</td>
<td>~40% of facilities providing treatment service</td>
</tr>
<tr>
<td>De-worming of children</td>
<td>0%</td>
</tr>
<tr>
<td>Iron fortification or supplementation</td>
<td>0%</td>
</tr>
<tr>
<td>ITN</td>
<td>17%</td>
</tr>
<tr>
<td>Conditional cash transfers</td>
<td>N/A (&lt;1%)</td>
</tr>
</tbody>
</table>

FOOTNOTES

146 Food and Nutrition Council, Zimbabwe National Nutrition Survey, 2010. This figure represents coverage as reported from the latest National Immunisation Days, which took place subsequent to the 2010 Nutrition Survey, which approximates 97 per cent.

149 Food and Nutrition Council, Zimbabwe National Nutrition Survey, 2010
Fortification of staple foods is another effective mechanism for delivering key micronutrients. Salt iodization has proven highly effective at controlling iodine deficiency disorders in Zimbabwe, however currently there are no other large scale fortification programmes. A National Food Fortification Task Force is currently exploring options for both commercial and point of use fortification with other micronutrients. The treatment of acute malnutrition has evolved considerably over the past decade, and Zimbabwe has adopted the community-based management of acute malnutrition (CMAM) approach. While coverage of treatment services has expanded dramatically over the past 5 years, there remain considerable gaps. Today, just 40 per cent of eligible health facilities offer state of the art care for severe acute malnutrition, and there is little integration between CMAM services, HIV services, and Infant and Young Child Feeding counselling. Despite a long-standing tradition of supplementary feeding in Zimbabwe, there are currently no large scale targeted supplementary feeding programs to address moderate acute malnutrition. The World Food Program (WFP) has included supplementary feeding for moderate acute malnutrition in its 2011-2012 Program Plan, but coverage will be quite limited.

4.5.4 Preventing Maternal and Child Undernutrition

Malnutrition in Zimbabwe is preventable. Global evidence suggests that the delivery of a limited set of high impact "direct" nutrition interventions such as exclusive breastfeeding could reduce chronic malnutrition at 36 months of age by 36 per cent, reduce mortality by 25 per cent, and reduce disability adjusted life years associated with undernutrition by approximately 25 per cent. Further, the promotion of improved complementary feeding practices alone could reduce chronic malnutrition by more than 15 per cent. Table 3: Addressing malnutrition in Zimbabwe, provides a list of "direct" interventions with proven effectiveness in reducing malnutrition along with their relative national coverage. The delivery of "indirect" interventions such as food security and agriculture interventions can contribute to even greater reductions. Social protection programs and broad-based poverty reduction are strongly correlated with improved nutritional status. Successful implementation of priority interventions requires that four primary conditions be met: target populations must have access to the services or supplies promoted, the services or supplies must be of acceptable quality, the target population must demand and have capacity to adopt the service (for example, knowledge, attitudes, and skills), and there must be an accommodating social and policy environment in place.

Access to, and quality of, key services and supplies

The National Nutrition Department (NND) within the MoHCW is responsible for defining policy and overseeing the delivery of direct nutrition interventions. The Government's delivery infrastructure includes a small team of nutritionists at national level, a cadre of Provincial and District Nutrition Assistants, district level health personnel, Village Health Workers (VHW), and more than 140 non-governmental organisations. Despite this potentially robust infrastructure, there remain considerable constraints to ensuring access to key nutrition services and supplies. Maternal micronutrient supplements are not reaching their targets, less than 40 per cent of eligible health facilities...
deliver state of the art treatment for acute malnutrition, stock-outs of key nutrition supplies are common, there are limited coordinated efforts to improve infant and young child feeding, and just 42 of 255 targeted hospitals across the country have been certified “baby friendly” over the past decade (four in the past three years). Staff turnover is high and reporting is sporadic and lacks the necessary quality and depth to drive decision making.

The Government has long recognised the multi-sectoral nature of nutrition. In 1998 the Government established the Food and Nutrition Council (FNC) with the mandate to “promote a cohesive national response to the prevailing household food insecurity and malnutrition through co-ordinated multi-sectoral action.” Since its inception, the FNC has been under resourced and understaffed and consequently has a difficult time carrying forward its mandate. A report recently released by the FNC and partners identified four key priorities for strengthening coordination of cross-sector food and nutrition security analysis and action in country:

- The establishment of a Food and Nutrition Security Analysis Unit within the FNC.
- The expansion of the mandate of the existing ZimVac to more effectively accommodate the interests of the broad range of food and nutrition stakeholders in Zimbabwe.
- The establishment of a Strategic Advisory Group (SAG) for the FNC comprised of key government and non-government stakeholders.
- The re-invigoration of District Food and Nutrition Management Teams.

These priorities are expected to provide a platform for the multi-sector action necessary to deliver essential nutrition services. One important outcome of the report development process was broad based agreement among stakeholders to use the Conceptual Framework for Analysing Causes of Malnutrition as the organising principle for joint action moving forward.

Within the MoHCW, integration appears to be a considerable challenge. Ninety-three per cent of pregnant women attend at least one antenatal visit, yet just 25 per cent receive iron supplements. Until recently, supplies of Ready-to-use Therapeutic Food (RUTF) were handled outside of the essential drugs delivery system, and nutrition is poorly represented in the training and scope of work of VHWs. Improved collaboration between departments within the MoHCW is critical to the delivery of interventions such as exclusive breastfeeding, the management of acute malnutrition, maternal micronutrient supplementation, and de-worming.

### Demand for nutrition services

The delivery of high quality health and nutrition services is necessary but not sufficient to ensure use of promoted practices and services; people must also demand the services offered and have the skills required for adopting promoted practices. Less than 10 per cent of children in Zimbabwe are receiving a minimal acceptable diet, less than 6 per cent are exclusively breastfed and the CMAM programme has a default rate greater than 20 per cent. There is limited information on potential barriers to adoption of optimal nutrition practices, and few rigorously tested messages or materials for the promotion of nutrition related practices and services.

### Social and Policy Environment

Zimbabwe lacks clear policy parameters and strategic road maps for nutrition planning.

**Policy Constraints:** In 1998 the Zimbabwe Cabinet tasked the FNC with developing a Food and Nutrition Security Policy. Despite a number of attempts, the policy has not yet been drafted. In 2009, key government stakeholders again endorsed the FNC’s mandate to develop the policy, and FAO, WFP, and UNICEF have been working closely with the FNC to move this agenda forward. The Food and Nutrition Security Policy (FNSP) will provide an important platform for cross sector collaboration and will strengthen the FNC’s coordination mandate. The policy is critical for guiding the development of sector specific strategies to address malnutrition.

In addition to the FNSP, the MoHCW has been working on an Infant and Young Child Feeding policy - the latest draft was circulated in September 2010. The policy is...
designed to support, protect and promote optimal infant feeding practices though evidence based interventions, but still requires vetting prior to finalisation.

**Legislative Constraints:** Globally, legislation has proven an important tool in addressing structural constraints to the delivery of priority nutrition practices and services. Zimbabwe has embraced a number of key pieces of legislation with regard to micronutrient supplementation and infant and young child feeding, including:

- Endorsement of Universal Salt Iodisation for the control of IDD (1998)
- (draft) Maternity Act to support breastfeeding mothers at work (2001)

While enforcement of universal salt iodisation has been rigorous, enforcement of other legal instruments has been less successful.

**Strategy Constraints:** There is currently no broad based food and nutrition strategy in Zimbabwe, nor a clearly defined nutrition strategy within the MoHCW. Following the development of the FNSP, a comprehensive nutrition strategy will be required. The strategy development process is expected to be in late 2010. In the interim, MoHCW has drafted an HIV and Nutrition Strategy.

**Guideline Constraints:** Up to date guidelines for ensuring coherent - evidenced based action are largely absent in Zimbabwe. Supplementary feeding guidelines developed in the late 1990’s are out of date, infant and young child feeding guidelines are antiquated, and guidelines for the Community Based Management of Acute Malnutrition are incomplete. On a positive note, dietary guidelines for people living with HIV were updated in 2009 and should be released shortly, and guidelines for the Vitamin A and Iron/Folate supplementation are updated on an annual basis. Clearly articulated state of the art guidelines are critical to ensuring effective, coordinated action across the country.

**4.6 Conclusions and recommendations**

Zimbabwe made remarkable progress in the twenty years following independence towards reducing infant, child and maternal mortality, and malnutrition. Supportive policies, sound programmes, a primary health care approach, and dedicated and well-trained health professionals underpin Zimbabwe's ability to meet its health goals. The past ten years have witnessed a decline in many child and maternal health indicators, but these declines are not irreversible. Further policy development, targeted financing, and programmes that address persistent inequity can contribute to Zimbabwe exceeding previous achievements. Areas for urgent consideration include:

**Strengthen investments in the health systems:**

- Mobilise resources to supplement the government budget to achieve the objectives set forth in the Health Sector Investment Case.
- Enforce the no user fee policy nationwide for HIV and maternal and child health services. Use mechanisms such as the Health Services Fund for payment to facilities to ensure user fees are not charged. Empower communities to hold health facilities accountable for enforcing the no-user fee policy.
- Develop strategies for retaining qualified health personnel, particularly in key posts.
- Promote task sharing among various cadres to widen coverage of services.
- Strengthen the national health management information system, including strengthening maternal and newborn death audit systems, to better inform policies and programming.

**Develop and implement an integrated maternal, neonatal and child health strategy that includes HIV and nutrition, with an emphasis on district hospitals and rural health centres:**

- Use the recently approved Child Survival Strategy and the ZNASP as the basis for integrating maternal services, building upon Zimbabwe's integrated approach to service delivery.
- Implement the 2010 WHO Guidelines on PMTCT, ART and Infant and Young Child Feeding, with accelerated efforts to achieve universal coverage of PMTCT, early infant diagnosis and treatment for HIV exposed infants and children, and provision of ART for maternal health.
Health and Nutrition of Children and Women

- Roll out the Child Survival Strategy with the aim of reducing child mortality.
- Support pre-service training, refresher training, and supervision of PCNs to deliver integrated services, including HIV testing and counselling, essential maternal and newborn care, post-partum family planning, and integrated management of childhood illnesses.
- Support community based care for mothers and newborns, including early home visits.

Reduce chronic malnutrition, with particular emphasis on addressing disparities between districts, wealth quintiles, and boys and girls:

- Promote exclusive breastfeeding and timely introduction of appropriate complementary foods.
- Provide zinc in the management of diarrhoea.
- Pursue national de-worming of children.
- Continue food fortification with iron, maternal iron/folate supplementation and neo-natal Vitamin A supplementation.
- Integrate Water, Sanitation and Hygiene strategies, such as handwashing with soap.
- Although rates of acute malnutrition are moderate, provide inpatient and outpatient therapeutic care for severely malnourished children and supplementation for moderately malnourished women and children.

Strengthen delivery of quality nutrition related services, increase demand for key practices and services, and develop an enabling social and policy environment:

- Enhance the nutrition delivery infrastructure, including monitoring and evaluation, with particular emphasis on the national and district level.
- Improve the coordination and mainstreaming of nutrition activities across agencies and sectors and within the MoHCW.
- Improve capacity of both government and non-government stakeholders to deliver state of the art nutrition interventions, including development of state of the art guidelines.
- Develop a comprehensive behaviour change strategy and tested IYCF communication materials.

- Conduct further analysis to better inform nutrition policy, guidelines and practices:
  - Conduct further research on the relationship between HIV and nutrition in Zimbabwe to better understand why children are not exclusively breastfed or receiving the minimum acceptable diet; why boys are more likely to be malnourished than girls; and why chronic malnutrition is on the rise while acute malnutrition has stayed relatively steady over the past decade.
  - Explore the feasibility and relevance of adopting maternal multiple micronutrient supplementation, maternal calcium, protein and energy supplementation, maternal de-worming, delayed cord clamping and zinc supplementation.

Strengthen community capacity to access health services and adopt healthy practices:

- Support women and children to identify their rights to health care and equip them with the knowledge, skills and resources to claim them.
- Strengthen community participation in primary health care and disease prevention through implementation of the Village Health Worker Strategic Plan (2010-2013).

Strengthen HIV prevention efforts for young people (15 to 24 years)

- Expand HIV testing and counselling services, with a special emphasis on young men.
- Strengthen the relevance of social and behaviour change communication interventions for young people, focusing on consistent condom use, particularly in age disparate relationships, and reduction in multiple partnerships.
- Promote access to male circumcision for HIV negative men aged 15-29.
- Expand children and young people’s access to HIV testing and counselling, support and treatment through health facilities, schools and communities.

- Develop a Food and Nutrition Policy and five year strategies for the Food and Nutrition Council and MoHCW.
5. Education

5.1 Background

The expansion of both primary and secondary education was a major success story in the early years after Zimbabwe’s independence in 1980, and represented a significant investment in the future. Extensive investment was made in teacher education, as well as curriculum development. Early Childhood Development (ECD) centres were established for the first time in rural areas. A nation-wide adult literacy campaign was launched in 1983, and by 1988 there were around 24,000 learners enrolled in adult literacy groups across the country. Enrolments at the University of Zimbabwe rose to 8,000 in 1989, from 1,481 in 1979 and 4,482 in 1985.

Major reviews and revisions of education strategies and targets were made as a result of changes in the socio-political and socio-economic environment in the 1990s. The government moved away from free tuition to cost-recovery and cost sharing, and reduced expenditure on education as a measure designed to reduce the budget deficit. Public sector expenditures on education declined from 7.7 per cent of GDP in 1990 to 4.7 per cent in 2000-2002. Nonetheless, Zimbabwe met the original target of universal primary access by 1990, and was able to report the highest adult literacy rates in sub-Saharan Africa well into this decade.

Despite the relative stability of the enrolment figures, quality indicators show a sharp deterioration during the period 1990 to 2009. In particular, the curriculum was no longer directly relevant to the social and economic situation of the country, as it had not been updated since the beginning of the 1980s. Furthermore, teacher morale has fallen and many trained teachers have been lost to the diaspora. In 2008, teachers responded to the economic crisis with a year-long strike. Schools closed for almost an entire academic year as teachers’ salaries dropped to the equivalent of less than USD 2 per month and many teachers chose to leave the country. The disruption of education in 2008, particularly in rural areas, had a profound impact on the sector. Throughout 2008 there were reports, particularly from rural areas, of politically-motivated attacks on teachers and teacher trade unionists.

The long-term systematic under-funding of education is largely manifested in the areas of school and learning supervision, lack of information for planning and policy, school infrastructure, and a crisis in the most fundamental relations for school governance - between communities and school management.

---

Footnotes:

165 UNICEF, Situation Analysis, 1990
166 UNICEF, Situation Analysis Update of Children: Poverty and Inequality in Focus, 2005
167 O’Mally, Education Under Attack, UNESCO, 2010 states that up to 45,000 teachers were lost during 2007/2008
168 O’Mally, Education Under Attack, UNESCO, 2010
169 MoESAC 2010, Draft Interim Strategic Plan Report, Harare, Zimbabwe
5

Education

The Ministry of Education, Sport, Arts and Culture (MoESAC) is developing a plan of action to revive both primary and secondary education provision (responsibility for tertiary education remains with the Ministry of Higher and Tertiary Education, MoHTE). The situation has exacerbated inequalities. Inequity in education attendance is more acute at the secondary school level, with children in the highest wealth quintile three times more likely to attend secondary school than those in the lowest quintile. Transition rates from primary to secondary education have been adversely affected and disparities in education between rich and poor have widened over time.170 (See Figure 31.)

Adult Literacy

The adult literacy rate rose from 55 per cent in 1970 to 85 per cent in 1994 and 97 per cent in 2003. Literacy rates for young adults are also high. In 2009, an estimated 99 per cent of all 15-24 year old male and female adults were literate.171 This high level of literacy is a direct reflection of the importance given to primary education since independence in 1980. However, Zimbabwe remains at risk of this level falling significantly as the examination pass rates continue to fall dramatically and enrolment in secondary education decreases. This will have a direct impact on the country’s economic and social development over the coming five years.

5.2 Legal, regulatory and policy frameworks

Zimbabwe is signatory to a number of international agreements that relate to the Right to Education: the African Charter on Human and Peoples’ Rights, the African Charter on the Rights and Welfare of the Child (ACRWC), the Universal Declaration of Human Rights (UDHR) and the Convention on the Rights of the Child (CRC). However, the Constitution of Zimbabwe, which serves as the country’s supreme law does not recognise this right.

Figure 31: Attendance rates for primary and secondary school, by quintile (Quintile 1 is poorest, quintile 5 richest).

Source: ZDHS 1999, 2005/6, MIMS 2009

![Attendance rates for primary and secondary school](image_url)

Source: ZDHS 1999, 2005/6, MIMS 2009

52

FOOTNOTES

170 Multiple Indicator Monitoring Survey, 2009
171 MDG Status Report for Zimbabwe, 2010
The Education Act, which is supported by statutory instruments and policy circulars, is the main piece of legislation governing education. Section 4 of the Act states; “every child in Zimbabwe shall have the right to school education”. The Act provides grounds on which no child can be refused admission or be discriminated against, and primary education is compulsory. Disability, however, is not addressed specifically. Gender was included as a basis for non-exclusion in the 2004 amendment. A 2004 review of Zimbabwe’s legislation in the context of the CRC concluded that the provisions of the Education Act “meet the basic requirements of Article 28 of the CRC”. Zimbabwe endorsed the Education for All (EFA) goals and signed the EFA Dakar Declaration in 2000. In an effort to achieve the EFA goals by 2015, Zimbabwe launched a National Action Plan of Zimbabwe in 2006: ‘Education for All Towards 2015’, which specifies the six EFA goals that were outlined in the Dakar Framework.

The ACRWC, UDHR, CRC and EFA all state that primary education should be provided for free. This was the case in Zimbabwe from independence until 1991, but section 6 of the Education Act now states tuition should be provided for ‘the lowest possible fees’. Although the Basic Education Policy states that no school head should refuse admission of pupils even whose school fees was not paid, in reality, education is no longer a right which is accessible to all children. The refusal of admission of pupils discriminates against the poor.

Further to the approved legislative instruments related to education, there are three policy circulars that are worth highlighting. Policy Circular Number 5 (2009) allows schools to use 10 to 15 per cent of their levy for teacher incentives. Levies are paid by parents and were originally intended to cover non-personnel costs. Schools are guided by a circular which states that all matters of sexual abuse should be immediately reported to the police and the District Social Welfare Office. The circular emphasises that the best interests of the child must be the primary focus throughout procedures in the context of sexual abuse. Guidelines cover circumstances in which pupils or family members are involved as perpetrators, but there is no mention about what actions should be taken when a teacher is accused or suspected of involvement in abuse. The circular provides no guidance on the suspension, investigation and further actions regarding the investigation of teachers. A 2009 study revealed that 10 per cent of secondary school pupils and 2 per cent of primary school pupils surveyed reported having been forced into sex by a teacher.

The proposed Basic Education Policy (2006-2010) is guided by the MDGs and EFA goals. The policy recommends that the Education Act be amended to include a section that protects children from all forms of child abuse, especially physical and sexual abuse, child labour and violence. The policy also recommends that corporal punishment, which is still widely used, should be abolished. Factors relating to discipline in schools - suspension, expulsion, exclusion and corporal punishment - are covered in detail in the Care and Protection for Children and Women chapter.

5.3 Government leadership and commitment

The two Ministries responsible for the provision of education are the Ministry of Education, Sport, Arts and Culture (MoESAC) and the Ministry of Higher and Tertiary Education (MoHTE).

The draft 'Cost and Financing of the Education Sector in Zimbabwe' study which was carried out early in 2010 provides an overview of the fiscal environment for education from 1990 until present. The share of primary and secondary education in the total government budget increased appreciably from around 14 per cent in the early 1990s to 20 per cent by 2005. However, it contracted very sharply to just 8.4 per cent in 2008, and was 12 per cent in 2009. MoESAC and MoHTE are currently advocating for an allocation of at least 20 per cent of the national budget. The graphs presented in Figure 32: Breakdown of education budget in 2009 national budget illustrates the projected and released budgets in 2009 and how these allocations were spent.

FOOTNOTES

172 Education Act, Chapter 25:04, Amended 2004
173 Tsanga A et al, Children and Women’s Rights in Zimbabwe Theory and Practice, 2004
174 EFA Goals: Early childhood development, Access to primary school, Life-long skills, Adult literacy, Gender equality in education and Quality of Education.
175 MoESAC, Proposed Basic Education Policy 2006-2010
178 MoESAC, Proposed Basic Education Policy 2006-2010
Ninety-five per cent of the total funding allocated to MoESAC in 2009 was committed to paying teacher salaries, set at approximately USD171 per month. The human resource cost of education provision has resulted in a steady erosion of the ministry's ability to finance capital costs. According to the draft 'Ministry of Education Strategic Plan for 2010', no funds were available from the released 2009 budget for capital costs. Furthermore, provincial revenues were uneven, (see Figure 33: Education Revenue by Province 2009) with financial allocations not necessarily being based on current and projected needs. While an education system may be able to function for some period of time with no investment made in capital costs including physical facilities, textbooks, learning materials, furniture and equipment, in the longer term this will lead to a major reduction of the quality of the service delivered. In Zimbabwe, this has been painfully illustrated by the precipitous decline in student examination pass rates over the past five years from between 60-70 per cent to less than 40 per cent for Grade 7.

**FOOTNOTES**

179 This graph indicates the final revised budget that was submitted to the Ministry of Finance for approval. From this, actual figures released showed no financial support to any capital expenditure. Teacher salaries were increased by the Public Service Commission (PSC) half way through the year (2010) from $150/month to an average of $171/month, which resulted in 99% of the total budget for the Ministry being used for recurrent expenditure. As a result, no funds remained for quality improvements including teacher training, facilities upgrading, textbook purchases or curriculum review.
Government and international donor funding to the education sector has been seriously affected by the absence of a fully costed strategic plan which outlines sectoral priorities. In 1999, the Government of Zimbabwe commissioned a major review of the education sector. The Presidential Commission of Inquiry into Education and Training (1999), commonly known as the Nziramasanga Report, recommended that extensive reform was required which until now has not been possible given the economic crisis that the country experienced. Although many programmatic suggestions were presented, there has been little scope for these activities to be implemented given the limited financial assistance to the sector, which has also been underpinned by the lack of a strategic direction. In order to overcome this, at the beginning of 2010, MoESAC embarked on a process of sector planning. The Ministry’s education sector plan consists of two phases, firstly to develop a one year ‘emergency’ plan for 2011 with a limited set of priorities given the constrained fiscal environment, followed by the development of a medium-term plan (2011-2015) and related budget. The planning process which began in earnest in May 2010 has included the voices of central, provincial and district level education stakeholders. As a result of this consultative process, five major priorities emerged which address issues of teachers, learning environment, quality of learning, school governance, and the need to focus resources on those students who are most marginalised. A detailed and fully costed plan is being developed. In order to implement and fund the priorities identified through the strategic planning process, MoESAC will work closely with their donors and partners through the established education coordination mechanisms in the country.

The year 2010 has marked a significant change and reinvigoration of the education sector with partners who are committed and eager to support educational activities and a Ministry with renewed enthusiasm to collaborate with international partners and drive its own objectives forward through the strategic planning process. The sector now represents one of change and opportunity.

FOOTNOTES

180 Government of Zimbabwe, Presidential Commission of Inquiry into Education and Training, 1999

181 The most important recommendations of the report are still relevant in today’s context and suggest 1) that basic education should be changed from a 7 to 9 year programme of junior school (compulsory for all), towards teaching life and entrepreneurial skills that lay the foundation for higher education (vocational, technical or academic); 2) a review of the curriculum to reflect a more competency-based learning approach which is better linked to local industrial needs; and 3) facilitating access to education which is more in line with student’s interests and economic priorities translating into a complete review of the secondary and technical/vocational training related to general academic, business and commercial, and technical and vocational subjects.
5.4 Essential Services

5.4.1 Teaching Personnel

There are 14 teacher education colleges in Zimbabwe which come under the jurisdiction of the Ministry of Higher Education. Each college develops its own curriculum independently which is then accredited by the Teacher Education Department of Zimbabwe University. Teachers become certified after passing their final exam at the teacher education colleges (see Figure 34). Once certified they enter the profession, but are not formally required to update their certification status. A teacher code of conduct is laid down by the Public Services Commission which outlines what is expected of a professional teacher. However, the professional teacher’s associations are yet to develop a code of conduct for teachers similar to that of other professional sectors.

During the rapid expansion of the education sector after Independence, significant strain was placed on the education system, especially with regard to the number of available teachers. As such the Ministry of Education introduced an innovative new scheme called ZIMTEC which provided on the job training for O’level graduates so that they could become qualified. The new approach put apprentice teachers into the classroom as supervised teachers in their second year, and they returned for further training in their third year. Teachers were placed into the classroom more quickly, thereby ensuring that their additional year of formal training was based on significant practical experience. It also increased the effective capacity of the teacher colleges by a third. An additional benefit was that the practice teaching, which normally took place in schools nearby the teacher colleges, was now occurring in rural schools, too. This initiative received extensive financial and technical support and a broad range of teaching modules were developed. In 1988 the newly established Ministry of Higher Education took over the mandate for training teachers. Limited support has since been provided to the technical colleges that offer training programmes and today only two colleges still offer the ZIMTEC programme, Morgan and Gwanda ZIMTEC.

At the beginning of 2009, with the introduction of multiple currencies in the economy, a flat remuneration rate of USD 100 for all civil servants was established by the Government. Further changes were made during the year, but a national civil service strike during the beginning of 2010 prompted the Civil Service Commission to review all civil service salaries. Beginner qualified teachers are now paid USD 171 per month and head teachers USD 212. Given that the current poverty threshold for a family of three children is approximately USD 500 per month, most teachers are living below the poverty line. As such, communities are
asked to compensate for this gap with teacher supplements, paid by parents, which is an added ‘fee’ or ‘incentive’ beyond the financial realm of poorer families. The re-appointment of teachers has since been slower than expected. Of the 3,988 teachers who have re-applied for teaching positions under an amnesty agreement with the Ministry of Education, only 2,591 have been re-employed.186

New enrolments in Zimbabwe’s 14 teacher colleges have also fallen dramatically. Teacher college enrolment stood at 17,808 (10,163 women) in 2007, and in 2009, had dropped 24 per cent to 13,567 (8,722 women).184 According to the National Education Advisory Board (NEAB) Study (2009), “The teaching profession is now shunned by young people. Only those who have failed to find other avenues of employment end up training as teachers”.185

The number of teachers in 2010 is still below 2006 levels, with critical shortages in the mathematics and science subjects in particular. This shortage is more acute in rural than urban areas. Although MoESAC has authorised 138,950 positions, (including teachers and administrators), 38,000 positions are vacant. To fill this gap the Ministry recruited 15,378 temporary teachers,186 who typically have less training.

The Ministry’s recommended pupil-teacher ratio for primary schools is 1 teacher to 40 pupils. The Ministry currently reports a total national average Pupil Teacher Ratios (PTR) of 37 which is below the national benchmark. While this ratio is applicable in all urban schools, in rural provinces the reported PTR is 40 and above. There is great variety in the PTRs across the country; more than 15 per cent of schools in Bulawayo, Harare and Midlands provinces have PTRs below 30 whereas 26 per cent of schools in Matabeleland North and 16 per cent in Matabeleland South have more than 50 pupils per teacher. On the other hand the average pupil-teacher ratio for rural and urban secondary schools is 1:22 and 1:23 respectively. The national average pupil-to-school ratio (PSR) gives the average school size as 458 and 1,031 pupils per school for rural and urban schools respectively.

Teacher ratios however mask the problem of teacher attendance. Teachers are required to teach for a minimum of 22.5 and 25.5 hours per week for grades 1 to 2 and 3 to 7 respectively. While there is no official record of actual teacher attendance levels at schools, it is widely reported during field monitoring visits by educational partners that teachers often do not teach the minimum hours required given their need to seek alternative economic opportunities to supplement their salaries. Poor teacher attendance is further exacerbated by the lack of supervision provided by Ministry district staff given limited transportation facilities. Furthermore, as mentioned earlier, fully qualified teachers are sought after in other more highly paid professions and as such teacher attrition rates remain high187.

Teacher attrition rates are further exacerbated by low remuneration levels, limited opportunity for professional promotion in the system and inadequate in-service training and supervision, all of which have led to a rapid decrease in regard to teaching conditions.

Furthermore, specialised training programmes for teachers, especially in the area of special needs education, is limited. With up to 300,000 children with disabilities facing exclusion from the education sector, this will continue to be an area of great need. There is only one college for primary education, namely United College of Education in Bulawayo, that offers an in-service two-year training programme for special needs education. Until recently, focus of this training was on the education of children with mental retardation, visual and hearing impairments, targeting a rather narrow field of special needs education. The college has now taken on the challenge of bringing other issues, usually referred to as ‘learning difficulties,’ into the curriculum of both their special needs education programme and general primary teacher training programme. Other colleges are also starting with similar explorations to give more attention to issues that affect the learning of a child. The Better Schools Programme of Zimbabwe (BSPZ) currently funded by the Ministry’s primary schools department in each district is a platform for the in-service training of teachers at district level on various issues including those of inclusive practice. The BSPZ programme offers periodic workshops, but no detailed and practical certified courses in Special Needs Education188.

FOOTNOTES

183 MoESAC, Education Cost and Financing Study, 2010
184 MoESAC, Draft Interim Strategy, 2010
185 National Education Advisory Board, Rapid Assessment of Primary and Secondary Schools, 2009
186 All figures reported by the Department of Human Resources from the Ministry of Education, August 2010
5.4.2 Access to basic and secondary education

Zimbabwe has consistently maintained relatively high levels of primary school enrolment, as shown in Figure 35: Grade enrolment as a percentage of total enrolment in 2009.

Net enrolment ratios (NER) increased from 81.9 per cent in 1994 to a peak of 98.5 per cent in 2002, before experiencing a gradual decline since 2003. The Multiple Indicator Monitoring Survey (MIMS) 2009 recorded a NER of 91 per cent, lower than the over 96 per cent NER generally recorded between 2003 and 2006. There are no major differences between urban and rural areas, and although there is almost 100 per cent gender parity in primary schools, girls comprise only 35 per cent of the pupils in upper secondary. Female pupils and those in rural areas are more likely to drop out of school. According to the 2010 Basic Education Assistance Module (BEAM) rapid assessment, a combination of factors underpin these non-completion rates: poverty and lack of finance, poor or limited nutrition, the need to keep children at home to undertake household chores and informal employment, distances between school and home, and orphanhood.

The breakdown of government and non-government schools shows that community, church and private schools play a significant role in the provision of education in Zimbabwe. Of the total number of over 5500 primary schools, 94 per cent are run by non-government organisations. At the secondary level a similar trend exists whereby 88 per cent of the 1,644 schools are registered as non-government. These schools function with significant government financial support, including salaries for teachers, and are governed by MoESAC standards and regulations.

A safe and secure learning environment for children is a priority. In 2009, MoESAC adopted the principles outlined in UNICEF’s Global Child Friendly School initiative. The overall objective is to support the Government’s implementation of a Child Friendly Schools framework which ensures inclusiveness, gender-sensitivity, tolerance, dignity and personal empowerment through several complementary actions. Specific reference is made to school construction standards including Water, Sanitation and Hygiene (WASH) facilities, the quality of teaching personnel and child protection issues. This move coincided with the release of Plan International’s research report on child abuse in schools. The study found that children in most of Zimbabwean schools environments learn in fear of violence; yet to a large extent, the violence goes hidden, unrecorded and unreported. The Zimbabwe teacher unions have

---

**FOOTNOTES**

189 BEAM Rapid Assessment, 2010
190 MoESAC, Education at a Glance, 2010
191 UNICEF, Child Friendly Schools for Africa, 2009
192 Plan Zimbabwe (2009), Research Report on Child Abuse in Schools: A Baseline Study for the "Learn Without Fear Campaign"
expressed interest to develop a code of conduct for teachers in schools. However, a comprehensive strategy targeting school management, teacher education and curriculum reform is needed to address this issue; otherwise student drop-out rates and learning achievement standards will continue to be adversely affected.

It is estimated that about 30 per cent of children are unable to complete primary education and that only about half of those eligible go on to secondary education.\textsuperscript{194} This means that more than 190,000 secondary school age children are out of school per annum, creating a significant issue of longer term social instability due to unemployment and disenfranchised youth. Whilst enrolment in primary schools has remained stable, enrolment in secondary schools is falling, a situation which may be due in part to the rising cost of secondary education and the falling level of student learning achievement at the end of primary school. Ordinary level (O level) examination results are poor with less than one in five children achieving a pass; similar to 2005 levels. Advanced level (A Level) examination pass rates however are substantially higher and in fact increased from 78.74 per cent in 2005 to 79.82 per cent in 2009.\textsuperscript{195} This increase is partly due to fewer selected students sitting ‘A’ Level exams based on their chances of a successful outcome.

Early childhood education was introduced after independence through the National Early Childhood Development (NECD) program which was aimed primarily at pre-school children in rural areas who had never had access to these services. A community development approach underpinned the roll out of the ECD centres. With limited focus on minimum criteria, and lack of capacity at community level to make significant contributions, the standard of facilities and activities varied substantially. In 2004, a national review of the education system recommended that ECD be integrated into education structures rather than running parallel to them.\textsuperscript{196} The scaling up required to achieve this was considerable and there is limited data to suggest that it occurred. A national survey conducted by CSO in 2007 indicated that 95 per cent of primary schools had ECD facilities, but among 5,059 pre-schools surveyed, 61 per cent did not have buildings.\textsuperscript{197} A 2009 needs assessment conducted in five marginal districts noted that 94 per cent of ECD teachers were considered unqualified by MoESAC standards and 32 out of 50 schools visited did not have suitable classrooms, the majority of the remainder not having adequate sanitation facilities, furniture or equipment.\textsuperscript{198}

\textbf{FOOTNOTES}
\begin{itemize}
\item \textsuperscript{194} Government of Zimbabwe, 1999, Report of the Presidential Commission of Inquiry into Education Training
\item \textsuperscript{195} Central Statistics Office, 2007
\item \textsuperscript{196} [Author], [document name], [year]
\end{itemize}
A Situation Analysis on the Status of Women’s and Children’s Rights in Zimbabwe, 2005 - 2010: A call for Reducing Disparities and Improving Equity

Education

The Basic Education Assistance Module (BEAM)

In 2000 the Government of Zimbabwe, in conjunction with the World Bank, UNICEF and other development partners, designed a National Social Protection Strategy as the comprehensive framework for protecting vulnerable groups against risk and shocks. As a response to the emerging economic decline, the Government extracted four key components of the National Social Protection Strategy for quick implementation under the framework of an Enhanced Social Protection Strategy. These components included: the Basic Education Assistance Module (BEAM); Health Assistance Programme; Public Works Programme; and Children in Especially Difficult Circumstances Programme.

The major objective of the BEAM is to prevent poor households from resorting to negative coping mechanisms such as withdrawing children from school. BEAM supports vulnerable households with the payment of a basic education package that includes levies, school and examination fees. It is a national community-based social safety net that covers all primary and secondary schools, as well as special schools for children with special needs, and is implemented by Community Selection Committees (CSC) in conjunction with the Ministry of Labour and Social Services (MoLSS) and MoESAC.

BEAM was conceived in a relatively stable macro-economic environment with 900 000 primary and secondary school children supported with the payment of school fees in 2005. However in 2008, Government funding was rendered ineffective as a result of hyper-inflation which severely eroded the value of grants to communities.

Given the financial constraints faced by Government, BEAM has been revitalised with donor support from September 2009, under the UNICEF ‘Program of Support’ for Orphans and Vulnerable Children. In 2009, a total of 527,310 children benefited from BEAM. During the first half of 2010, BEAM benefited 573,245 primary school children. A social mobilisation campaign is being held to ensure that communities are aware of BEAM’s objectives and that the most vulnerable children benefit.

Several review and monitoring exercises conducted after the revitalisation of the programme show that the BEAM programme revitalization, while overall successful, has faced operational challenges that include delays in schools’ application submissions and the submission of wrong banking details. With the continued impoverishment of the population, more children are in need of assistance with school fees than the BEAM programme has funding to support. There is a need to review the selection criteria, level and scope of support provided by the BEAM programme in order to ensure that the programme benefits the most vulnerable children.
5.4.3 Special needs education

The Government aims to provide special needs education in order to bridge the gap for learners with special needs. According to 2004 data, there were 14,115 students with intellectual disabilities, 50,000 children with learning disabilities, 1,634 children with hearing impairment, and 2,635 students with blindness or visual impairment attending school. Zimbabwe is estimated to have 300,000 children of school age with a disability, yet the enrollment figures indicate that a large proportion of children with disabilities do not attend school.

While it is the policy of the Government not to discriminate against any child regardless of race, religion, gender, creed and disability, in reality, these children face serious access issues related to teachers' inability to support their special learning requirements. Due to resource constraints, MoESAC provides limited in-service training and support for teachers in special needs education.

5.4.4 Out of school youth and second chance education

Approximately one million secondary school age youth will be excluded from the education system in 2010. The principle behind ‘second chance education’ is to provide opportunities for youth who, regardless of their financial circumstances, are academically inclined as well as those who are not, to continue their education up to at least 16 years of age. The education curriculum and system currently does not provide opportunities for children to actively re-engage in the sector. The absence of catch up classes, high secondary school fees, and the lack of viable technical education facilities contribute to this problem. Real opportunities exist to link out-of-school education programs with life skills training, especially related to raising knowledge on issues related to HIV. While initiatives like these have been offered by MoESAC in the past, it has not been possible to continue or expand the programmes due to financial constraints.

5.5 Technical education

Zimbabwe’s expanding economy but falling educational status for the country’s youth, emphasises the need to invest in an alternative educational route such as technical and vocational skills development. Skills-based training for young people in Zimbabwe is limited and constitutes a marginal sub-sector in the education system.

The education sector aims to provide an economically relevant education to all students, including skills based training. In 2007, MoESAC outlined policy guidelines on the implementation and broadening of curriculum through increasing the variety of technical and vocational (tech-voc) subjects. More than 100 tech-voc subjects are now taught in schools.

FOOTNOTES

200 MoESAC, Education Management Information System, 2004
201 This number has been calculated using the WHO estimate of 10 per cent of children worldwide suffer from disabilities which can then be translated into 300,000 children or more in Zimbabwe.
202 Dolata S et al, “SAQMEC Policy Issues Series: How Successful are HIV-AIDS prevention Programme: No. 3 Sept, 2010 The issue of students’ knowledge of HIV and AIDS is reflected in a high quality survey conducted by a team of SACMEQ researchers on student and teacher knowledge of HIV and AIDS. The study was administered in late 2007 with around 60,000 Grade six pupils and their teachers in over 2,500 schools across the 15 SACMEQ countries. The study found an alarmingly low level of knowledge about HIV and AIDS among Grade six pupils in all countries, but of the 15 countries involved, Zimbabwe was ranked number 13.
203 MoESAC, Policy Circular Number 39, 2007
Second Chance Education Opportunities for Out-of-School Youth

It is estimated that between 10 per cent and 15 per cent of children have never attended primary school (MoESAC Draft Strategic Plan, 2010). Presently, only 47 per cent of children completing the primary cycle of education enrol in secondary schools. This percentage is lower than the drop-out figure for the 1993 grade 1 cohort, which, eight years later, in 2000, recorded that 196 000 children did not proceed to secondary education. If this continuing and expanding drop-out rate for each cohort is calculated up to 2009, it means that about two million secondary school aged youths have had no access to education or vocational training, for the last eight or nine years. Socially and economically, this large group of youth will have had few opportunities, if any, to develop practical skills. Consequently they likely face a life of poverty.

Although MOESAC is endeavouring to resuscitate non formal education, a lack of funds is hindering this process. The real question, which needs to be discussed by youth, educationalists and vocational and technical experts, is: what educational opportunities should second chance education provide for youth?

For academically inclined youth whose parents cannot afford formal schooling, a second chance at continuing to study academic subjects should be offered through mentor supervised study groups, supported by distance learning materials and backed up by radio and CD support programmes. For the less academically inclined, second chance education must continue to offer opportunities to acquire basic competencies in literacy and numeric skills, while offering a variety of vocational options designed and developed to meet emerging market and service requirements.

Materials presented as modules should be self-contained, so that when successfully completed, each module acts as a stepping stone for youth to proceed to the next more complex level. The ‘vocational’ option should include a strong adolescent sexual and reproductive health course. This life skills course could be presented on radio using drama, discussion groups and health experts, with a write-in component. Obligatory business skills modules based on real income generating activities should be part of the core curriculum. Finally, a highly interactive curriculum component on human rights, democracy, citizenship, integrity and being part of a community, should be part of the curriculum. Vocational options requiring hands on access to basic skills in order to develop competencies would need to be guaranteed.

Secondary Schools or Technical Colleges with vocational facilities could be offered special grants for allowing out of school learners to use facilities at set times. Possibly these hands on courses should be conducted during school vacations. Different levels of certification could be arranged so that students could proceed to more advanced studies.

Perfecting second chance education and vocational opportunities will depend on consistent dialogue with the concerned youth, engaging schools with vocational and technical workshops and producing unique and exceptional study group materials and supportive radio programmes.
Policy revisions have reinforced the provision of technical and vocational education in schools and MoESAC allows schools to recruit an additional tech-voc teacher for every 100 students enrolled in school\textsuperscript{124}, which is above the usual teacher quotas. Despite this, the quality and scope of tech-voc training in Zimbabwe is limited. Training of tech-voc teachers is primarily undertaken in Polytechnic Colleges\textsuperscript{125} and not clearly linked with Teacher Training Colleges,\textsuperscript{126} limiting teachers’ pedagogical skills in the classrooms.

As MoESAC develops the new strategic plan and as the wider curriculum review process begins to receive much needed international support, the integration, reform and support of the technical-vocational sector within the wider education sector is in need of urgent and continued attention.

5.6 Learning process

Zimbabwe’s student curriculum, assessment and examination system were identified by the 1999 Nziramasanga Commission as needing major review.\textsuperscript{207} The decline in examination pass rates is the clearest representation of the overall decline in the quality of the education system and is illustrated in Figure 36: Ordinary and advanced level pass rates - 2005-2009.

Ordinary level examination results have been consistently poor for the past 10 years. Student performance at the 7th grade have shown a significant drop from pass rates of over 70 per cent in 2007 to less than 40 per cent in 2009. This masks the unequal distribution of the decline across provinces, so that some provinces report pass rates as low as 22 per cent, while others remain in the high 70 per cent range. The results for pupils completing Form Four and writing the Zimbabwe Schools Examination Council (ZIMSEC) Ordinary level exams indicate a systematic failure to provide children with a meaningful education. Pass rates at these very low levels significantly disadvantage children by limiting their ability to continue their studies into secondary school and beyond, and if persistent over time, act as a deterrent for parents (and children) to sustain the financial and opportunity costs of education in the face of on-going economic constraints.

![Figure 36: Ordinary and advanced level pass rates - 2005-2009](image)

Source: MoESAC, Education at a Glance: 2009

What Children Like

- "Being able to go to school without fear of being sent back home by teachers for non payment of fees."
- "Not walking long distances in search of work to earn money for school fees and books."
- "Having a meal at the accelerated learning centres"

What Children Don’t Like

- "Being beaten in school, at times for things they have no control over for example not having a USD 1 for paying teachers."
- "Teachers having relationships with pupils in schools."
- "Teachers making children do domestic chores in their house."
- "Being labeled by teachers and other children by the name of the organisation providing education assistance to them"

FOOTNOTES

\textsuperscript{124} Teachers may be recruited as long as the school can demonstrate that they are ‘fully employed’. In other words teachers are teaching 32 periods per week.

\textsuperscript{125} There are approximately 13 Polytechnic Colleges in Zimbabwe with at least one in each province.

\textsuperscript{126} There are approximately 14 Teacher Training Colleges in Zimbabwe with at least one in each province.

\textsuperscript{207} The Nziramasanga Commission recommended the introduction of nine years of basic education followed by a three pathway specialisation for the third and fourth year of secondary school: academic, commercial and technical-vocational. Public examinations at Grade seven and Form two would be discontinued and replaced by in-school examinations; ending automatic promotion, with children progressing to the next grade only if they could perform satisfactorily at each level. Mathematics and science education were to receive particular attention, with alterations being made so that emphasis was placed on scientific and mathematical thinking and problem-solving. For the majority of students, pure mathematics would be replaced by something more relevant to their lives. Guidance and counseling was to be introduced at all levels of the schools and civic education would become a teachable subject. Many of these recommendations remain valid.
Facilities and adequate learning materials for primary school students are of continued concern. A rapid assessment of schools conducted by the National Education Advisory Board (NEAB) in 2009 found that among the 120 schools surveyed, 74 per cent of primary school classrooms were in need of minor or major repairs. At least a quarter of rural primary schools had broken classroom furniture. According to 2009208 MoESAC statistics209 30 per cent of children share one seat with seven or more students.

In addition, MoESAC has reported that the textbook to student ratio currently stands at 1:10 or worse. This crisis will be addressed through textbook distribution activities planned through the Education Transition Fund (ETF) which will provide every child with a full set of textbooks. Additional emphasis is being placed on providing learning materials in minority languages and Braille. While this should be seen as a land mark phase for education in Zimbabwe, there remains scope to expand this to include complementary age appropriate reading materials and reference books for older students.

The content of the existing curriculum and its structure is another cause for poor student performance. Reform of the National Education Curriculum has been identified by MoESAC as a major priority in the 2010-2015 Strategic Plan.

5.7 Family and community capacities

5.7.1 Family financing

The capacity of communities to financially contribute to the education of their children is becoming a growing issue. As Government investment has decreased, families are being asked to fill the resource gap which is estimated in many cases to be double the State investment.210 The bulk of operational expenditure at government primary and secondary schools is currently funded from student fee and levy income. School Development Committees (SDCs) have been authorised by MoESAC to set and collect prescribed fees and levies and although MoESAC has issued guidelines to schools on how student levies can be spent, most schools do not distinguish between fees and levies, nor do they adhere strictly to given regulations for expenditure priorities.211 An estimated one-third of all school children are now considered 'disadvantaged', but despite this parents are still being asked to contribute between USD 2 and USD 5 admission fee for primary school students and up to USD 292 for secondary schools.212 Increasing teacher incentives has resulted in complaints from some parents who believe that Government is reneging on its role to pay employees and transferring the burden to already 'indigent' communities.213 Furthermore, parents are asked to contribute to teacher supplementary payments which vary significantly between urban and rural areas, with little contributions being possible in more remote areas of the country. Student examinations bear an additional cost. As such, fewer students are able to sit for their exams, teacher recruitment in rural areas is difficult and school enrolments are falling significantly in secondary schools. A summary of financing burden on families is provided in Table 4: School fees and levies.

**FOOTNOTES**

208 Chakanyuka S et al, Study conducted by National Education Advisory Board, *Rapid Assessment of Schools, 2009*
209 MoESAC, *Education at a Glance, 2010*
210 NEAB, *Rapid Assessment of Primary and Secondary Schools, 2010*
212 Ibid
213 National Education Advisory Board, Parental and Stakeholder Involvement in School Governance for Committee on School Development Committees, 2010
The Education Transition Fund

The Education Transition Fund (ETF) is a USD 50 million, transitional financing mechanism for development partners to jointly support the MoESAC to lead the reinvigoration of the education sector in Zimbabwe. Established in September 2009, the ETF provides a platform for donors to provide assistance to the education sector, whereby the Ministry provides the strategic direction on priorities, policies and programmes and UNICEF manages the funds, with other technical partners providing support as required. The fund is therefore a transitional approach that provides donors the opportunity to adhere to the principles of Aid Effectiveness in a complex political environment, while contributing to national scale results and the revitalization of the sector as a whole.

The ETF provides coordinated, coherent donor support for key education priorities. The rapid assessment conducted by the National Education Advisory Board revealed that over 20 per cent of primary schools had no textbooks at all for the compulsory subjects of Shona or Ndebele, Mathematics and English. The current average textbook ratio is 10 pupils to one book, but in more remote and vulnerable rural areas this ratio is significantly exceeded.

The main aim of the ETF is to improve the quality of education. In year one, the specific objective is to procure and distribute full sets of core curriculum text books (four subjects) to all 5,500 primary schools in Zimbabwe, to ensure a maximum ratio of two pupils to one text book. In addition, ETF will support pupils with stationery kits including exercise books, rulers, pencils and pens, together with registration books and teachers’ guides for every primary school. Steel cabinets are being provided to schools to secure the longevity of the books and learning materials. An estimated 2.8 million pupils will benefit from this distribution of teaching and learning materials.

Two members of every School Development Committee (SDC) will be trained to maximise the educational potential of the new textbooks and to strengthen the schools’ capacity to handle and store books. The SDC provides a bridge between the community and the school, so members will also receive training on strengthening parental engagement with schools to increase the feeling of ownership for the materials distributed and increase their responsibility for their children’s education.

The ETF has also mapped all schools, including satellite schools, in 71 out of 73 education administrative districts, using GPS, and has updated the Zimbabwean Schools Map. The ETF is also supporting the MoESAC with the provision of technical assistance to support policy development, planning and implementation capacity. Staff assistance in legal information, communications technology, and strategic planning will be provided to support the Ministry with the development of its strategic plan.

The ETF plans to support secondary school textbook procurement and distribution, and all secondary schools have been surveyed to determine current textbook usage. An annual review of the ETF is planned in September 2010 which will jointly define priorities and budgets for the next phase, which will focus more on addressing education quality and outcomes.

The ETF is the first national-scale assistance to the education sector in more than a decade and is a good example of what can be achieved through a collaborative partnership effort in support of priorities identified by the Government for the benefit of children.
5.7.2 Parental participation

The decision by Government to establish SDCs in all government and non-government primary and secondary schools marked a turning point in the role of communities in the development and running of their schools.

<table>
<thead>
<tr>
<th>Role of the SDC (non-government school)</th>
<th>Role of the SDC (government school)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preserve and maintain school property</td>
<td>Preserve and maintain the school property and facilities</td>
</tr>
<tr>
<td>Pay for goods and services received by the school</td>
<td>Engage or hire, academic (over and above the existing teacher establishment) and non academic staff</td>
</tr>
<tr>
<td>Hire non-teaching staff and pay wages and salaries</td>
<td>Undertake the construction or the installation of new buildings and facilities and carry out alterations, additions, improvements or repairs to existing buildings with the Secretary’s approval</td>
</tr>
<tr>
<td>Charge development levies and collect any other money from any source</td>
<td>Repair and make good any damages to fixed property</td>
</tr>
<tr>
<td>Buy insurance policies to protect property</td>
<td>Award and make available scholarships and grants</td>
</tr>
<tr>
<td>Hire legal services</td>
<td>Provide financial assistance for children who would otherwise not be able to attend school</td>
</tr>
<tr>
<td>Establish a fund in the name of the school</td>
<td>Increase levy in any period of not less than twelve months</td>
</tr>
<tr>
<td>Borrow money and collect fees</td>
<td>Charge a capital development levy for a fixed number of terms</td>
</tr>
<tr>
<td>Receive grants and donations</td>
<td>Submit a budget to justify increase in levy or charge levy for capital development</td>
</tr>
<tr>
<td>Invest funds in savings accounts or in securities</td>
<td></td>
</tr>
<tr>
<td>Prepare a financial statement at close of each financial year at annual general meetings</td>
<td></td>
</tr>
<tr>
<td>Do all other activities that promote education in the school</td>
<td></td>
</tr>
</tbody>
</table>

---

**Table 4: School fees and levies**

<table>
<thead>
<tr>
<th>Payment beneficiary</th>
<th>Type of School</th>
<th>Amount USD</th>
<th>Purpose of payment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>School Levies</strong></td>
<td>School (determined by the SDC with consent of parents and final approval for the levy given by provincial ed. office)</td>
<td>All schools with fees; often higher in private and non-state schools</td>
<td>Often schools do not distinguish between fees and levies and charge one amount. P1 (low density primary) USD 60/term</td>
</tr>
</tbody>
</table>
| **Tuition Fee**     | Ministry of Education. Council schools collect by the Council Bursar | Primary urban schools and all secondary schools | P2 (high density primary) USD 30/term  
P3 (rural primary - 80%) USD 3/term | Controlled by Ministry and should be used only for purchase of teaching and learning materials and school running costs |
| **Examination fees** | ZIMSEC (collected by schools) | Examination council | USD 5-20 (grade 7)  
USD 5-15 per subject (O and A levels) | Cost of personnel to develop and administer the examinations |
| **Unofficial teacher Supplements** | Teachers and groups of teachers | Most schools | Varies by school $1 to $5 for school holiday teacher payments or extra lessons | To additionally contribute to teacher salaries |

---

²²² MoESAC, Secretary’s Circular Number 5, 2009
Despite the existence of a clear set of guidelines for the roles and responsibilities of the SDCs, many members have yet to read the relevant statutory instruments. Teacher incentives have become an issue within communities, leading to tensions between SDCs, parents and school heads.

5.8 Monitoring progress

The ability of the Government to effectively monitor and supervise teaching and learning practices underpin the quality of the system as a whole. In 1990, MoESAC decentralised many of the administrative decision making processes in schools, allowing head teachers to have the flexibility to respond more efficiently to their own schools specific needs. However, the development of standards, curriculum content and teacher conduct are still governed by head office.

While the structures may exist to provide adequate monitoring and supervision of the education sector, MoESAC suffers from a crisis in funding and therefore staff appointments. In 2010, more than 40 per cent of district education officer positions remain vacant. Supervision capacities are severely affected with a 24 per cent decline in school visits recorded between 2006 and 2009. MoESAC owns an average of two vehicles per province and only 8 districts out of 73 have vehicles. Furthermore only 30 districts out of 73 have reported having computers.

As long as supervision and monitoring continue to be issues, levy collection by SDCs will continue unabated, teachers will not be given the support needed to improve teaching quality and educational staff who may contravene school rules and regulations (especially in light of child protection issues) will not be held accountable for their actions.

Weak supervision capacity is compounded by inaccurate and untimely school based data. MoESAC has been developing programmes to improve data collection quality since the early 1990’s and operates within the framework of ‘Strengthening the National Education Statistics Information System’ (NESIS), now integrated into the Africa Development Education Authority (ADEA). This grew out of the realisation that informed policy formation thrives on, and is informed by the availability of accurate, reliable and timely data. Despite these developments accurate school-based data continues to be a challenge and further support is required at the central, provincial and district level to collect, enter and analyse data from the school level to more effectively inform policy and planning activities.

5.9 Conclusions and recommendations

Zimbabwe’s education system, once the envy of the region, now faces immense challenges. The sector is characterised by a lack of financial and human resources, low teacher and administrative morale, poor hygienic conditions in most schools, severe shortages of essential supplies and high school fees which have prevented many children from entering and continuing their education. Positive national education statistics have tended to mask the real problems within the system, such as poor academic performance of students, irregular teacher attendance and unsatisfactory progression rates from primary to secondary schools. Demand for education remains high, but if the quality of the education provided continues to decline at its current rate, far fewer families will be willing to make the high financial sacrifice required for their children to attend school and the education gap between the rich and poor will continue to widen at an unsatisfactory rate. A quality education system that serves all children underpins the future development of any country and Zimbabwe is no exception.

Despite the system remaining fragile, there is great scope for investment. The success of the ETF demonstrates that there is both international and national commitment to restoring the education system to what it once was, with scope for the rapid expansion and improvement of the sector as a whole. The Government has demonstrated commitment to lead the restoration of the sector through the finalisation of its interim investment plan which focuses on directing resources to support teachers, improving school and system infrastructure, restoring the quality of teaching and learning, reinvigorating education system governance and focusing resources on the most marginalised. The recommendations below build on the direction already provided by the Ministry of Education, Sports, Art and Culture.

Legal and Regulatory Framework of the Sector

- Include the right to a free education in the new Constitution

---

FOOTNOTES

Education

- Conduct a review of the Education Act
- Review all legislation and policy circulars to clarify school fee and levy payments
- Develop a more robust system which investigates any teacher accused of abuse and strengthen the MoESAC child safeguarding policy
- Advocate for a ban on corporal punishment in schools

**Government Leadership and Commitment**

- Strengthen monitoring and supervision capacity of MoESAC
- Support MoESAC to develop a comprehensive EMIS system including technical and financial assistance along with the needed ICT equipment at the national and provincial level
- Complete the Interim and Medium term strategic plan for MoESAC with strong involvement of civil society and other partners in the education field
- Advocate for a higher proportion of the national budget to be allocated to education, including sufficient resources for supply and infrastructure needs
- Implement a well managed results based financial management system within MoESAC
- Develop and enforce clear guidelines for community financial contributions to schools (especially teacher salaries)

**School Environment and Management**

- Complete and analyse school level data to gain a picture of actual student numbers, attendance and attrition rates and develop strategies to address all barriers to access to education
- Implement an emergency funding appeal for the rehabilitation of school facilities which includes minimum water and sanitation requirements with a complementary programme of school grants
- Develop clear guidelines for Child Friendly Schools, including WASH
- Support a national SDC training programme on roles and responsibilities, statutory rights and limitations with a view to improving the relationship between school committees and communities, with pupil participation embedded in the process.

**Access for the most marginalised**

- Support MoESAC to conduct after school 'catch-up' education programmes
- Support scholarships and other bursary mechanisms to ensure that girls are able to complete their secondary education

**Learning Quality**

- Support MoESAC to develop a clear strategy which incorporates technical and vocational educational opportunities
- Introduce a competency based framework for the curriculum
- Introduce the recommendation of the Nziramasanga Commission for a two-track education curriculum which provides for academic and technical skills development
- Improve the inter-linkage between ZIMSEC and the CDU
- Provide support to ZIMSEC to review the examination system and content
- Introduce a system of continuous learning assessment at the school level (to complement SACMEQ)
- Provide a full set of textbooks for all students in primary and secondary schools with additional complementary reading materials for young children and reference books for older students

**Human Resources**

- Provide support to the teaching training colleges to develop a programme for 'special education'
- Conduct a complete review of communities' contributions to teacher incentives, ensuring that this issue is embedded in the legislative framework of education
- On the basis of an analysis of teacher demand, supply, recruitment, training, management and professional development, design a 5 year programme to improve teacher supply, utilisation and effectiveness
- Improve teacher living conditions through the provision of teacher accommodation and other non-financial incentives
- Work with teacher unions, the public service commission and teacher colleges to develop a 'teacher code of conduct' and a set of teacher professional and academic standards
- Revise pre-service teacher education curriculum to include a common set of competencies directly linked to the students curriculum framework
6. Water, Sanitation and Hygiene (WASH)

6.1 Background

Overall Situation

The water and sanitation sector has a proud tradition in Zimbabwe with significant investments in water storage, irrigation, urban water and sewer services and rural water and sanitation facilities. The sector is supported by key legislation, including the Water Act Chapter 20:29, the Public Health Act, the Environmental Management Act, the Rural and District Councils Act, and the Urban Councils Act. Water resources are managed by catchment basins and water and sanitation services by local councils. The economic downturn and lack of capacity to manage aging infrastructure has had a significant impact on the quality and reliability of services. Following a serious cholera outbreak in 2008, emergency humanitarian relief has commenced in many urban centres to rehabilitate sector infrastructure. Government has sought to rejuvenate the sector, clarifying roles and responsibilities. This is a sector facing major challenges. Without recovery in the WASH sector, Zimbabweans will face more deaths, illnesses, pollution of rivers and water courses, continuing poverty, and negative impacts on livelihoods, industry, and tourism - resulting in more hardship, particularly for women and children.

Water Resources

Zimbabwe is a semi-arid country which is heavily reliant on regular rains (generally November to April). Mean annual rainfall is low and many rivers in the drier parts of the country are not perennial. The country is prone to extreme weather conditions including droughts, floods and cyclones. Climate change predictions are that this variability will intensify. Cyclones and floods frequently create a WASH emergency, contaminating water sources and washing away infrastructure, leaving vulnerable communities with no safe source of drinking water or possibility of safe excreta disposal.

Zimbabwe has the second highest per capita water storage capacity in Southern Africa, with extensive investment in large, small and medium dams, though current utilization is only about 22 per cent of mean annual run-off. Yet, competition for fresh water is high. Major non-consumptive fresh water uses include hydro power generation on Kariba dam, recreation and navigation, fisheries and ecosystem sustenance, while consumptive water uses include agriculture, drinking, industrial, commercial, institutional, mining and conveyance and final treatment of urban wastes.

Footnotes:

6. This section draws heavily from the Zimbabwe Country Status Overview, Draft 3, AMCOW, June 2010.
7. Rainfall declines from North to South (mean annual rainfall above the Zambezi escarpment is 800mm, while in Beitbridge it is 400mm) and East to West (1200mm in the Eastern highlands to 500mm in Tsholotsho district). Zimbabwe's mean annual runoff is 19.9x10^9m^3, excluding flow in international rivers, the Limpopo and Zambezi.
The water resource sector has been badly hit by the economic downturn and lack of investment has nullified many of the reform gains. Rivers are now unregulated, inadequate attention has been given to the maintenance of key water resource infrastructure with a high risk to public safety from the breach of dams, and catchment plans are not implemented. Pollution (from untreated sewerage, mining and run-offs from weakened on-farm management systems) and high sedimentation rates threaten rivers and water storage reservoirs. Many major towns and cities in Zimbabwe are upstream of their drinking water sources and this has led to high water treatment costs, huge pollution loads, and the proliferation of invasive alien species, including water hyacinth.

6.2 Water and Sanitation Coverage and Sector Performance

At independence in 1980, Zimbabwean inherited a well-developed urban sector and a neglected rural sector. Key milestones in WASH are presented in Table 5. Despite significant efforts to develop a rural infrastructure, the imbalance between urban and rural services remains a distinctive feature of the sector: 98 per cent of those without an improved drinking water source live in rural areas and up to 42 per cent of the rural population practices open defecation. Zimbabwe’s scorecard\textsuperscript{219} (which assesses the pathway by which money is turned into water supply and sanitation services in the four sub-sectors (rural water supply, urban water supply, rural sanitation and urban sanitation)) reflects the extreme challenges that the sector now faces, especially in planning, budgeting, equity, output and maintenance (water supply) and markets (sanitation).

Table 5: Milestones of Water and Sanitation Development in Zimbabwe

<table>
<thead>
<tr>
<th>Date</th>
<th>Key Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>1980</td>
<td>National Independence</td>
</tr>
<tr>
<td>1981</td>
<td>ZIMCORD</td>
</tr>
<tr>
<td>1987</td>
<td>National Action Committee (NAC) established with MLGRUD in the chair</td>
</tr>
<tr>
<td>1987</td>
<td>Integrated Rural Water Supply and Sanitation Program (IRWSSP) initiated</td>
</tr>
<tr>
<td>1999</td>
<td>Water Act promulgated</td>
</tr>
<tr>
<td>1999</td>
<td>Establishment of Zimbabwe National Water Authority</td>
</tr>
<tr>
<td>2004</td>
<td>Draft Domestic Water Supply and Sanitation policy submitted to cabinet</td>
</tr>
<tr>
<td>2006</td>
<td>Urban water assets transferred to ZINWA</td>
</tr>
<tr>
<td>2008</td>
<td>Government of National Unity (GNU) established</td>
</tr>
<tr>
<td>2008</td>
<td>Urban water assets returned to local authorities</td>
</tr>
<tr>
<td>2008</td>
<td>Outbreak of national cholera emergency and emergency response</td>
</tr>
<tr>
<td>2009</td>
<td>Cabinet appoints MWRDM to lead the water sector</td>
</tr>
<tr>
<td>2010</td>
<td>Ministers’ leadership Water Retreat</td>
</tr>
<tr>
<td>2010</td>
<td>Cabinet approves amended sector responsibilities</td>
</tr>
<tr>
<td>2010</td>
<td>NAC re-launched</td>
</tr>
</tbody>
</table>

\textsuperscript{219} See the Zimbabwe CSO.
The exact coverage of water and sanitation services in Zimbabwe is unclear. Government figures, derived from Ministry of Health and Child Welfare (MoHCW) data on sanitation coverage, the National Action Committee (NAC) inventory and urban council estimates, estimate that in 2008, 46 per cent of Zimbabweans had access to improved drinking water and 30 per cent to improved sanitation facilities. Figure 37 shows the historic trend (1990 to 2008), as well as the projected increase in coverage that needs to be achieved in order to reach the MDGs.

Figure 37: Trends in Water Supply and Sanitation Coverage Using Commonly Accepted Estimates

Figure 38: Trends in Zimbabwe Water Supply Coverage 1990 to 2010 Using JMP Estimates

Figure 39: Per cent of households without access to safe water supplies, 1990-2010.

Source: JMP Estimates

Figure 40 shows how sanitation coverage has stagnated, with only a slow improvement in open defecation over the 20 year period since 1990.
Urban services in Zimbabwe were built to a high standard and by the late 1990s had achieved a high level of coverage. The implosion of the economy, collapse of the public sector investment and limited external financing from 2000 has meant minimal new investments in service delivery for nearly a decade. The failure to repair or maintain an already aging infrastructure has led to a severe decline in services. Reports from urban settlements, including growth points, give a consistent picture of high levels of pumped water that is not accounted for, distribution systems in need of repair, and effluent and raw sewage outflows entering rivers and dams, which are often the major sources of bulk water supply. Lack of water flow causes frequent sewer blockages. Water treatment plants are dysfunctional, do not have the power to pump consistently or lack chemicals. Intermittent power supply to water services is a major contributing factor.

Revenue streams to service providers have fallen dramatically. The collapse in public sector salaries led to a significant exodus of skilled staff. Capacity shortages in the public and private sectors have appeared along the entire value chain: from local manufacturing and supply of essential equipment, spares, chemicals and commodities, management of water treatment and waste water plants, engineering

Figure 40: Sanitation Coverage Trends, 1990 - 2010

Power and Water Security in Zimbabwe

Zimbabwe is also facing an energy crisis. Its infrastructure is dilapidated and there is insufficient electricity generation capacity (meeting only 57 per cent of demand). Power is essential to extract, treat, and transport water, as well as power sewage treatment and is one of the largest cost items for water service providers. Power outages have serious impacts upon water and sanitation services by (i) reducing the volume of water pumped, both reducing water usage by consumers and affecting the functioning of sewers; (ii) increasing costs, both for service providers and consumers; (iii) decreasing revenue through less water sales; (iv) reducing the effectiveness of water treatment; (v) increasing contamination; and (vi) increasing the risk of pipe bursts.

A rapid assessment of urban water suppliers in Zimbabwe found that intermittent power supply is a major, but preventable cause of erratic water services, worsened water quality and cost escalation. On average, power is out for 8 hours per day in all water utilities. Outages mostly occur at peak supply times, when water is most needed. Some water treatment facilities, such as Rusape, experience up to 14 hours of outage per day.

The assessments found that inexpensive modifications to existing power supply networks and amended policies by the Zimbabwe Electricity Supply Authority (ZESA) could significantly improve water services. Water operators can reduce power outages by: (i) entering into agreement with ZESA to avoid shedding to key water installations, e.g. Harare; (ii) connecting water services to a nearby existing unsheddable line, e.g. Chegutu; or installing an unsheddable line, e.g. Kadoma; or (iii) modifying switching at the local substation to maintain power supply to water services, e.g. Chipinge. Policy makers should elevate the status of water services to being "unsheddable". Donors should prioritize support to the energy component of water services.

supervision, finance, administration, project design, contract management, policy guidance, and necessary skills at provincial, district and village levels.

The inability of vulnerable populations to access safe water and basic sanitation, combined with a collapsed health care system, have resulted in frequent diarrhoeal and cholera outbreaks in the country. The cholera outbreak frequency has shifted from every ten years in the 1980s and 1990s to now being an annual occurrence. In 2008, a nationwide cholera epidemic spread to 55 out of 62 districts, as well as into neighbouring countries, (refer to Text Box: Cholera Epidemic in Zimbabwe: 2008-2009). The outbreak was not an isolated phenomenon, but a red flag indicator to the state of national neglect of the sector. Apart from the specific lessons learned in the evaluations, one major lesson was that investing in preventing cholera through repairing and revitalizing the WASH infrastructure may be a far more cost-effective strategy than responding to outbreaks. Diarrhoea also remains one of the top ten diseases affecting under-fives in Zimbabwe\textsuperscript{220}, causing around 4000 deaths among children under 5 every year.

6.3 Rural Services

JMP analysis of rural water and sanitation access shows a surprisingly limited increase in coverage from independence, despite Government’s efforts to invest in rural and resettlement areas. The rural sector developed a well-coordinated program, the Integrated Rural Water Supply and Sanitation Program (IRWSSP), based on government-subsidized, donor-financed, low-cost, local technologies (Bush pumps, Blair Ventilated Improved Pit - BVIP - Latrines). Zimbabwe was also a forerunner in establishing government-supported, community management of rural water points.

In the last decade, rural water development and management have deteriorated sharply. Maintenance and repairs virtually ceased: Government could no longer provide spares; many community water-point committees stagnated; and pump-minders were no longer employed. The 2004 WASH inventory estimated that 75 per cent of the 47,000 hand pumps in the country were not functioning and it is generally agreed that there has been further deterioration since then, except where NGOs have rehabilitated or maintained services. Pilferage has affected the functioning of many water systems, especially irrigation, pumping and solar equipment. The collapse of commercial farming has removed what service provision there was for farm workers, and added a significant additional burden to the state in servicing the resettled populations. The breakdown of rural water points has meant increased use of unprotected water sources and further drudgery for women and girls, who bear the brunt of walking long distances to fetch water.

The JMP data also shows a slight increase in rural sanitation coverage during the 1980s and 1990s, despite a vigorous rural sanitation program in this period built on innovative technologies, a disciplined cadre of environmental health extension workers and the distribution of government subsidies to cover the cost of building materials, which could not be sourced on-site. Recent assessments show a significant decline in rural sanitation sector performance. With capital subsidies drying up, few new facilities have been built. With ageing superstructures, full latrine pits, unavailability (and un-affordability) of cement, many rural families have reverted to open defecation. Figure 40 indicates that 42 per cent of the rural population still practice open defecation\textsuperscript{221}. Plan International and other NGOs in Zimbabwe are exploring various behaviour change approaches to improving rural sanitation. Poor quality and less water, and increased faecal pollution have led to a much-worsened health environment for women and children. This is exacerbated by the decline of support for health and hygiene education. Lack of transport, materials, skilled staff and budget have undermined a once strong program, leaving Zimbabwe’s vulnerable population further exposed to the risk of infectious diseases and epidemics.
Cholera Epidemic in Zimbabwe: 2008-2009

From August 2008 through July 2009, one of the largest cholera epidemics ever recorded in Africa plunged Zimbabwe into a catastrophic public health crisis. The outbreak, which initially started in Chitungwiza, a peri-urban suburb of the capital Harare, spread quickly to other high-density suburbs in Harare and soon moved to rural areas across the country. By the time the epidemic ended, nearly 100,000 (98,592) cholera cases and 4,288 deaths had been reported, 62 per cent of which occurred at home. All 10 of Zimbabwe's provinces were affected, including 55 of the country's 62 districts.

The 2008-2009 cholera outbreaks occurred amidst a deepening complex political, economic and humanitarian crisis. Government institutions were at their weakest and service delivery systems had all but collapsed. Poorly maintained water and sanitation infrastructure fuelled the crisis, and a poorly functioning health care system contributed further to the epidemic's spread.

By November 2008, it was clear that the outbreak could not be contained. The UNICEF Zimbabwe Country Office (ZCO) shifted to full emergency mode on 16 November, adopting an initial 120 day emergency response plan, which was later increased to 180 days. Other agencies followed, implementing their own activities. Zimbabwe's Minister of Health and Child Welfare (MoHCW) publicly declared the cholera outbreak to be a national emergency on 3 December 2008, and requested international assistance. The official declaration gave the international community a green light to deploy resources and mobilize a coordinated response.

Humanitarian agencies, development partners and NGOs coordinated their response through the Interagency Standing Committee (IASC) Cluster Approach, a mechanism, introduced globally in 2006 to help ensure greater predictability, effectiveness and efficiency in the international humanitarian response to disasters. UNICEF led the WASH cluster along with Oxfam as co-lead; the World Health Organization (WHO) led the Health cluster; and the World Food Program (WFP) the Logistics cluster.

Major lessons learned from the outbreak included:

- Early and rapid response is crucial, especially in high population density areas
- Be prepared - readiness requires that contingency plans be developed and regularly reviewed
- Involve government from planning through to recovery and use government structures
- Set up effective monitoring and surveillance systems. Data is essential for strengthening responses
- Investigate outbreaks promptly to identify transmission routes and to follow the evolution of the outbreak
- Promote government, civil society, donor partnerships from the start
- Involve communities, including village health workers, community mobilizers and hygiene promoters
- Raise both general and targeted awareness about cholera before the next cholera season
- Scaling up requires approval from authorities, which can take time
- Ensure financial and administrative mechanisms are flexible
- Address structural causes
- Consider the special challenges of urban outbreaks

About one in four people in Africa, that is a total of 228 million, defecate in the open. Of the ten countries in the world with the highest rates of open defecation (OD), 4 are in Africa (Ethiopia, Nigeria, Niger and Sudan). Countries with high OD are commonly fragile states or countries with large nomadic or dispersed populations.

Rates of open defecation have increased in some African countries (including Liberia, Mauritania, Somalia, Sudan), but 9 African countries (Angola, Benin, Botswana, Ethiopia, Madagascar, Malawi, Morocco, Mozambique, and Senegal) made decreases in OD between 1990 and 2008.

Figure 41 shows the relative percentage of population practising open defecation in Southern Africa countries.

An approach called Community-Led Total Sanitation (CLTS) has shown a remarkable impact on reducing OD. CLTS is a methodology for mobilising communities to completely eliminate OD. Communities are facilitated to conduct their own appraisal and analysis of OD and take action with their own resources to become ODF (open defecation free). CLTS is a whole-community, behaviour change approach, triggered by peer pressure. CLTS was piloted in Zambia in 2007 and resulted in an increase in sanitation coverage from 23% to 88% within a two month period. There was no evidence of open defecation to be found in 75% of participating villages. Findings confirmed the crucial role of traditional leaders in ensuring sustained community action.

CLTS assists people to recognize that OD is a threat to all in the community. In CLTS, public finance first focuses on mobilizing communities for behaviour change, not on subsidizing latrine inputs. Considerable success has also been shown by offering prestigious awards (output aid approaches) for communities reaching ODF status.

Countries have adopted CLTS in a variety of ways, emphasizing different components and using different names for the community behaviour change process. Its impact has been varied, but, in general, outcomes have been positive. In many cases large-scale programs - such as in Ethiopia, Zambia and Mozambique - have achieved significant decreases in OD in a short period of time. Key challenges are quality control of basic latrines, sustaining good behaviours and assisting households to move up the sanitation ladder when expenditure is beyond their willingness to pay.

Sources: JMP Data 2010; Harvey et al. 2008, Community-led Total Sanitation: Lessons from Zambia, UNICEF
6.4 Policy and Regulatory Framework

A strong and well-established legal framework guides the water and sanitation sector, but enforcement is now weak and the policy environment does not reflect current circumstances. Forward-looking legislation in the late 1990s and the Water Act laid the basis of catchment management throughout the country and created a Zimbabwe National Water Authority (ZINWA).

In urban areas, Zimbabwe has a well-established municipal framework with decentralized powers for Urban Councils. Water and sewerage departments in local authorities manage urban services, except those designated to ZINWA.225

In 1985 a National Master Plan for rural water and sanitation was produced, which created, among other things, a coordination framework for rural services. A National Action Committee (NAC) and its sub-national structures coordinated an inter-ministerial Integrated, Rural Water Supply and Sanitation Programme (IRWSSP). The NAC promoted the standardization of approaches and technologies, established operation and maintenance systems, and promoted hygiene through a Participatory Health and Hygiene Education (PHHE) program. Rural District Councils (RDCs) are the legal local custodians of development in districts and accountable for decentralized rural water supply and sanitation provision.

In 2004 the Government of Zimbabwe launched the Millennium Development Goals report and raised the 1999 target for access to safe rural water supply and sanitation from 79% and 58% respectively to 100%. It further specified the goal that every household should have access to a latrine within the homestead and to potable water within 250m by 2015.

In 2004 a draft national water and sanitation policy was produced and submitted to Cabinet, but was never endorsed. In 2009 a NAC review of the draft policy found that the policy needed to be updated to reflect the changed circumstances in Zimbabwe and to fill identified gaps. Identified issues included: (i) the need for clarity on sector leadership, (ii) clarification on financing instruments, (iii) sector regulation; (iv) approaches to climate change and environmental protection; (v) rural water maintenance and (vi) sanitation subsidies and behaviour change.

6.5 Institutional Framework

Roles and responsibilities for the water and sanitation sector are spread among several government institutions. The Government has recently clarified leadership and coordination roles. In June 2010, the Cabinet agreed on sector leadership, the responsibilities of key government ministries, and a coordination framework.

As reflected in Figure 42, the main sector roles are subdivided amongst the following Ministries:

1. The Ministry of Water Resources Development and Management (MWRDM) now leads the entire water sector and a redesigned NAC, responsible for sector coordination. NAC is supported by a National Coordinating Unit (NCU), which is being transferred to MWRDM. MWRDM has responsibility for water resource management policy and development and implements using its parastatal arm, the Zimbabwe National Water Authority (ZINWA).

2. The Ministry of Health and Child Welfare (MoHCW) has the responsibility for rural sanitation, environmental health education and public health. Through its Environmental Health Directorate, it also supports the development of family wells and simple community water supplies (springs, hand-dug or hand-drilled boreholes).

3. The Ministry of Local Government, Rural and Urban Development (MLGRUD) is the host ministry of Zimbabwe's Rural District and Urban Councils and establishes policy and supports the planning operations of the Councils.

4. The Ministry of Transport, Communications and Infrastructure Development (MTCID) hosts the Department for Infrastructure Development, which supervises rural infrastructure investment.

5. The Ministry of the Environment houses the Environmental Management Agency with responsibility for enforcing water pollution control.

6. The District Development Fund, a technical parastatal with responsibilities for rural water supply and maintenance for many years operated under MLGRUD. DDF was subsequently transferred to MTCID and now reports to the Office of the President.

FOOTNOTES

225 ZINWA manages water services in 538 small towns, growth points and other centres with weak capacity.
6.6 Financial Situation

The collapse of public sector finance and dwindling revenues are the major issues limiting water, sanitation and hygiene operations. During the period of hyperinflation, sector allocations became virtually worthless\(^{223}\) and established Government systems of financial disbursement were unused. The majority of sector finance is now off-budget humanitarian assistance and managed by NGOs. In 2009 in response to the cholera crisis, it is estimated that $85m was committed in humanitarian assistance to the WASH sector. In June 2009, the total current Government sector commitment was estimated at USD 39m. In 2010 the emergency response was shaped into an Emergency Rehabilitation and Risk Reduction (ER&RR) Program.

The WASH sector has been heavily dependent on donor assistance. Much of the aid has focused on urban areas, such as in the ER&RR program. Despite this significant donor assistance, the total investment gap required to meet the MDGs is estimated to be as large as USD 434 million (this scenario was built on cost estimates for meeting the higher MDG targets and assuming a planned annual sector commitment of USD 143 million). A significant portion of the required investment is for rehabilitating existing infrastructure. Tariff settings need urgent review, to generate the revenue needed to rehabilitate services, as well as to respond to reduced incomes. Tariff guidelines are needed which provide for equitable and transparent subsidy regimes and ring-fencing of revenues and expenses of water and sanitation departments. This is vital to enable accountability, transparency and adequate provision of funds for ongoing renewal and replacement of facilities. The discipline of payment of utility bills by Government institutions and other consumers has broken down and will not be easily restored.

---

**Figure 42: Zimbabwe Ministerial Coordination Structure for WASH**

**FOOTNOTES**

\(^{223}\) An AFDB 2007 sector assessment quotes a total annual sector allocation of Z$3 trillion (approximately $3m - using $1=Z$100,000). The value when spent would have been only a fraction of the allocation.
## 6.7 Equity

The 2009 MIMS survey confirms the finding of prior coverage analyses that Zimbabwe has a strong disparity between urban and rural areas in access to water and sanitation. Inadequate WASH has a greater impact on women, orphans and other vulnerable children, people infected and affected by HIV, and the poor in rural areas.

There is a strong gender imbalance in the WASH sector in Zimbabwe. Women do the great majority of manual and management work for water and sanitation services at the household level, yet have less control over household investment decisions. Women and girls walk long distances to fetch water in rural areas, depriving them of time to engage in economic activities to enhance their livelihoods, and yet at the same time they are not in meaningful decision-making positions at community level. Inadequate or lack of appropriate water and sanitation facilities at schools and domestic duties in the home mean that many Zimbabwean girls are forced to miss school or drop out of school. The gender distribution of skilled non-menial staff in the water sector - engineers, environmental health officers, and utility managers - is also highly skewed.

Zimbabwean urban areas also show great inequity in water use. Despite the comparative lack of slums in Zimbabwe, peri-urban areas have significantly poorer WASH coverage. The population in the peri-urban areas is the most vulnerable, as they are without appropriate WASH delivery systems and hence can be epicentres for transmission of disease.

---

### Emergency Rehabilitation and Risk Reduction (ER&RR) Programme (September 2010)

UNICEF established the ER&RR Programme in response to the 2008-2009 cholera outbreak specifically to address its underlying causes and prevent further outbreaks. The Programme is predominantly funded by the Australian Government Aid Programme, CERF, DFID, and ECHO (total of approximately $50 million in financial commitments). UNICEF-executed components and complementary activities by other leading sector agencies are expected to improve water and sanitation services for 5m Zimbabweans. The Programme initially focused on the high-density suburbs in urban areas (cities, towns and growth points) where the epidemic was most severe and populations most at risk, but is expected to expand into a national rehabilitation programme, as a foundation for sector recovery.

The Programme has 5 main components:

- **Rapid Assessments**: to identify emergency "quick-win" solutions to improve safe water and sanitation services (completed in 20 out of 23 targeted urban centres).
- **Emergency Rehabilitation** of infrastructure in urban and critical rural areas, including: urban rehabilitation works (ongoing in 7 centres, detailed design in 3 centres); training of water operators; procurement of essential equipment; and rehabilitating water supplies, institutional support and hygiene education in health institutions, schools and communities in "at-risk" rural districts.
- **Provision of Water Treatment Chemicals** to 20 Urban Councils and ZINWA as a cholera mitigation intervention. This component will be handed back to Councils in coming months.
- **Emergency Borehole Drilling**: 230 boreholes completed (plus 205 planned) in urban areas.
- **Coordination**: UNICEF and Oxfam coordinate emergency and urban sector agency activities, including donors, multilaterals, NGOs and government agencies and provide regular updates on WASH rehabilitation operations.
Recent UNICEF analysis of water and sanitation service access by wealth quintiles shows that access is extremely skewed by income. Figure 43: Sanitation Coverage Trends by Wealth Quintiles, Zimbabwe 1990 - 2010 shows the extreme situation for sanitation in Zimbabwe where the poorest have the worst service access. Sanitation subsidies do not reach the poorest 40 per cent of the population. Addressing equity is a significant issue when updating Zimbabwe’s sector policy.

**Figure 43: Sanitation Coverage Trends by Wealth Quintiles, Zimbabwe 1990 - 2010**

*Source: Special 2010 tabulation based on DHS 1994, 1999, 2004 and MIMS 2009*

---

The Absence of Slums in Zimbabwe

One of the distinctive features of the urban environment in Zimbabwe is the relative absence of informal settlements. Urban planning was fully functional until the late 1990s and urban growth was absorbed into planned infrastructure. The collapse of the economy in the early 2000s led to the spiraling of informal settlements. This population was cleared through a controversial campaign by the Government in 2005, known as Operation Murambatsvina, which sought to clear un-authorised structures in townships in Harare and other urban areas. Estimates of the numbers of people affected range from the United Nations estimate of 2.4 million people, to the police records of 120,000. This was officially characterised as a crackdown against illegal housing and commercial activities, and an effort to reduce the risk of the spread of infectious disease in informal settlements. A consequence has been a rapid increase in household sizes, meaning that pre-existing connections are now required to supply many more people than the population for which they were designed. The implication of this settlement pattern for urban water and sanitation services is extreme strain on the existing infrastructure. However, it also means a high proportion of consumers can be served with existing household connections, and since household connections have higher potential for revenue collection, this bodes well for cost recovery for urban service providers. The absence of slums historically in Zimbabwe has been a major advantage for urban development. Growth points, which are expanding in number however may pose similar risks of unplanned populations and inadequate social services.

---

**Rural and urban differences**

Children living in urban areas are significantly more likely to be residing in households using adequate water and sanitation facilities than children living in rural areas. Coverage of improved water and sanitation in rural areas is 68 per cent (water) and 50 per cent (sanitation.) (See Figure 44.)

**Figure 44: Percent children 0-59 months of age residing in households using improved water and sanitation facilities**

*Source: Zimbabwe National Nutrition Survey, 2010*
6.8 Conclusions and recommendations

The year 2010 is a turning point for the Zimbabwean water and sanitation sector. The cholera outbreak has been a stark reminder of the vital role that water and sanitation plays in society. WASH is now higher in the public consciousness, Government has responded with vigour, seeking to strengthen leadership and sector coordination, but is without resources. Donors are actively supporting emergency rehabilitation of services in 20 urban centres. Key actions are needed to seize these opportunities for sector recovery.

The Zimbabwe Country Status Overview draws three broad lessons which help to define strategic priorities for action:

- Leadership, clear roles and responsibilities and improved governance: Strong Government leadership is required to safeguard the sector. Roles and responsibilities in sub-sectors need to be clearly and transparently allocated on the basis of efficiency and effectiveness, without undue political influence. Governance arrangements are needed which, as well as giving Government perspectives, take cognisance of consumers, service providers, the private sector and NGOs.

- Policies need to be truly sustainable: A central lesson of Zimbabwe’s sector history is that sector policies need to focus on service sustainability. Institutional approaches, service levels, choice of technology, financing arrangements, maintenance incentives, environmental impacts, human resource policies, all need to be oriented towards the sustainability of services. Tough decisions need to be made to shift policies to what can be sustained by the much reduced resource base.

- Having Government solely responsible for sector development puts services at serious risk: Over-reliance on Government is a central lesson of Zimbabwe’s recent sector history. Government must lead and set a course. It must mobilize, influence, encourage dialogue between consumers and service providers to identify the best solutions, and avoid dependence on handouts.

A five-part strategy for action is needed for sector recovery:

Policy Development

Zimbabwe has been isolated from engagement in sector and regional debate in recent years and many of its policies do not reflect current sector thinking. The key policy issues that need addressing in the sector include:

- Urban water supply: A financing strategy for replacing aging infrastructure; an updated tariff policy that can improve service provider’s financial viability, as well address the needs of the poor; establishing regulatory mechanisms; increasing the accountability of urban service providers to consumers; encouraging greater private sector involvement in service management; creating autonomous utilities in Zimbabwe’s main cities; and applying objective efficiency measures in the allocation of management authority to local councils or ZINWA.

- Rural water supply: Establishing an effective maintenance and spare parts policy; clarifying the ownership of rural water assets; clarifying Zimbabwe’s rural drilling policy, including moving towards establishment of a well-regulated, competitive drilling industry, with clarity as to when DDF’s subsidized rigs can compete; rethinking the financing strategy for rural water services to give primary responsibility to local authorities and encouraging support from communities and the private sector; establishing a process for Zimbabwe to move towards a SWAp; and addressing the needs of resettled Zimbabweans.

- Urban sanitation and hygiene: Development of policies on lower-cost approaches for urban sanitation where full sewer services are unaffordable or cannot be managed.

- Rural sanitation and hygiene: Former subsidy-led approaches have proven to be less effective than previously thought: affordable financing strategies for rural sanitation need review; the policy of only having one standard option, the BVIP, should be replaced by a menu of options facilitating affordable entry to improved services; policies on pit-emptying and latrine replacement need clarification; modern behaviour change approaches should be adopted to create a demand for sanitation improvement and give priority to eliminate Zimbabwe’s high rate of open defecation; specific budget lines should be established for sanitation in national and local...
Water, Sanitation and Hygiene (WASH)

Hygiene promotion: Implement a dedicated hygiene improvement and cholera awareness programme in risk areas.

Leadership, Organization, Plans and Resources

Government's significant steps to re-organize and rejuvenate the sector need active follow-up. Next key actions are:

- Active sector leadership by NAC: Focus is required to ensure that the re-launched NAC and relocated NCU are fully supported to lead sector recovery. The Ministerial, NAC and NAC sub-committees should develop and implement a meeting schedule, workplan and budget.

- Sector strategy and plan: A sector recovery and development strategy needs to be developed, on the basis of which detailed sector development plans can be developed. A disaster risk management plan is also needed to address sector threats, including managing extreme climatic events.

- Address capacity: A sound capacity development strategy is needed, both to rebuild public structures (ministry, local authority, provincial, and district) and private sector institutions. Initiatives should include: greater use of professional engineering consultants, refresher training, improving the ability to manage outsourced contracts, and strategic use of technical assistance. It is unlikely the private sector will be willing to invest in water and sanitation services in Zimbabwe and take on significant risk in the current climate, but it would be beneficial to explore ways in which the private sector can augment capacity, improve cost recovery (through management contracts to improve billing) and operational and maintenance efficiency. Financing support to determine critical needs, improve service conditions and provide incentives for skilled Zimbabweans to return to fill key gaps might be considered.

- Annual joint sector review: NAC should institute a predictable annual cycle of sector planning, implementation and transparent sector review. This will build confidence, make strategic choices and attract resources.

- Leveraging financial resources: Investments will not be restored until Councils can demonstrate their ability for sustainable management of assets and

budgets; and sustainable sanitation service development requires long term partnerships between the public and private sectors.

Repair/Rehabilitation and Cholera Prevention

Immediate physical improvements to services on the ground are vital to save lives and address the hardship faced by women and children. It is useful to make the distinction between "repair" and "rehabilitation." Repair means fixing the immediate non-functioning components so that the facility can function. "Rehabilitation" means bringing the facility back to an 'as-new' condition. With regard to strategic prioritization, focus should first be on repairing critical non-functioning infrastructure, second on rehabilitating systems, and third on new investments. Repair and rehabilitation programs are needed in four areas:

- Urban water supply and sanitation: Deliver the existing ER&RR program and expand it to repair/rehabilitate non-functioning water treatment plants, pumps, wastewater treatment, distribution systems and on-site sanitation in all cities, towns and growth centres. Water services require reliable power supplies and priority is needed to make them "unsheddable". Local councils need assistance to secure their own regular supplies of water treatment chemicals, paid from their own resources.

- Rural water supply: Initiate a major program to repair and rehabilitate broken pumps and non-functioning boreholes and deep wells. The strategy should undertake rapid assessments to determine priority needs and then implement a rural repair and rehabilitation program to address these priorities.

- Rural sanitation: To meet emergency needs and reflect current international thinking on sanitation development, Government should first focus on eliminating open defecation. This requires implementing large-scale, modern, behaviour change approaches, participatory hygiene education and encouraging a sanitation services market, rather than leading by subsidizing latrine components. Environmental Health Technicians should facilitate latrine improvement, getting all households to adopt basic sanitation and assisting households to move up the ladder of improved service levels. The approach would include repair/rehabilitation of institutional sanitation (such as at schools and clinics); institutional sanitation would require subsidies.

- Hygiene promotion: Implement a dedicated hygiene improvement and cholera awareness programme in risk areas.
services. Priority focus should be on supporting councils to increase revenues to restore sustainability and capacity and improve operational efficiency. Immediate attention is needed for tariff studies to identify equitable and sound financial policies and practices and guide local authorities towards their implementation. Restoration of the Rural Capital Fund and development of an Urban Capital Fund, with good governance arrangements and policies that link capital investment subsidies to performance, would be a strategic method of using scarce resources. Once key financing policies are in place, NAC might consider hosting a water investment conference. See Tables 6 and 7 for annual investment and capital development requirements to reach the WASH MDGs.

**Sector Information**

A priority task is to establish a sound and updated sector information system so that sector management can be evidence-based and based on reliable information. Key actions are:

- Assessment of current status: An asset inventory is needed of urban and rural WASH infrastructure and an updated assessment of their status developed, using modern data collection and storage techniques. Focus is needed to better understand service disparities.
- Establish a sector information and monitoring framework: NAC should give priority to establishing robust and transparent systems for collection of data on water resources, urban and rural services. Sector information systems should adopt standard indicators, updating approaches, program-wide monitoring, and development of an annual joint sector review, reporting on a short list of key performance indicators. Information systems should link physical, usage and financial information to enable decision-makers to allocate resources efficiently. Study tours and specialized technical assistance on developing sector information systems might assist in identifying best practices approaches for Zimbabwean conditions.

### Table 6: Estimated annual investment requirements for water to reach the MDGs

<table>
<thead>
<tr>
<th>School Levies</th>
<th>New capital requirement</th>
<th>Replacement cost of capital stock (new and existing)</th>
<th>Estimated rehabilitation requirements</th>
<th>Total capital cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rural</td>
<td>43.4</td>
<td>33.2</td>
<td>50.0</td>
<td>126.6</td>
</tr>
<tr>
<td>Urban</td>
<td>60.5</td>
<td>16.0</td>
<td>250.0</td>
<td>326.5</td>
</tr>
<tr>
<td>Total</td>
<td>104.0</td>
<td>49.2</td>
<td>300.0</td>
<td>453.2</td>
</tr>
<tr>
<td>% rural</td>
<td>42%</td>
<td>67%</td>
<td>17%</td>
<td>28%</td>
</tr>
<tr>
<td>% urban</td>
<td>58%</td>
<td>33%</td>
<td>83%</td>
<td>72%</td>
</tr>
</tbody>
</table>

### Table 7: Estimated annual capital development requirement for sanitation to reach the MDGs

<table>
<thead>
<tr>
<th>School Levies</th>
<th>New capital requirement</th>
<th>Replacement cost of capital stock (new and existing)</th>
<th>Estimated rehabilitation requirements</th>
<th>Total capital cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rural</td>
<td>15.1</td>
<td>8.4</td>
<td>30.0</td>
<td>53.5</td>
</tr>
<tr>
<td>Urban</td>
<td>40.4</td>
<td>6.0</td>
<td>250.0</td>
<td>296.4</td>
</tr>
<tr>
<td>Total</td>
<td>55.5</td>
<td>14.4</td>
<td>280.0</td>
<td>349.9</td>
</tr>
<tr>
<td>% rural</td>
<td>27%</td>
<td>58%</td>
<td>11%</td>
<td>15%</td>
</tr>
<tr>
<td>% urban</td>
<td>73%</td>
<td>42%</td>
<td>89%</td>
<td>85%</td>
</tr>
</tbody>
</table>
7. Conclusions and Recommendations

The period of economic and political crisis in Zimbabwe, from 1997 through 2008, has had a devastating effect on the social sectors in Zimbabwe, on women and children's rights, and on the chances of Zimbabwe reaching the Millennium Development Goals (MDGs). The cholera outbreak in 2008-2009 is the event during the period 2005 to 2010 that perhaps illustrates most dramatically how far Zimbabwe’s once proud social services have fallen and how vulnerable Zimbabwe is today to major crises.

While cholera highlighted the chronic underinvestment in the water and sanitation infrastructure, other perhaps less dramatic examples occurred in other sectors. The virtual loss of an academic year in 2008 due to hyperinflation and teachers’ strikes demonstrates how fragile the education system has become. The social welfare system now relies on a total of around 100 social workers across the country. The measles outbreak of 2009 to 2010 illustrates both how much the expanded programme on immunisation has declined, as well as the fact that there are important segments of the population, including members of the Apostolic sects, which display very different care seeking behaviour to the general population and which need to be engaged more systematically in finding solutions to their public health problems.

However, there are four particularly striking pieces of data that deserve to be highlighted from this situational analysis. First, maternal mortality has more than doubled since 1990, the MDG baseline year. Second, newborn disorders, intrinsically linked to maternal health and nutrition, have now surpassed paediatric HIV as the number one cause of death among children under 5. Third, more than 40 per cent of rural Zimbabweans now practice open defecation as their only form of sanitation thus contributing to the disease burden and risking initiating a vicious childhood cycle of chronic infection and undernutrition. Finally, more than one third of all children under five suffer from chronic malnutrition or stunting, thus constraining their academic and income potential for life, and potentially constraining Zimbabwe’s economic development for generations to come.

In addition, while it is clear that the situation has deteriorated for the population across the range of wealth quintiles, it is also clear that for many indicators, the poorest have borne the brunt of the burden of the implosion of the Zimbabwean economy and collapse of social safety nets. As income inequality has increased and user fees become the norm, increasingly a woman and child's access to such critical services as skilled birth attendance, transition from primary to secondary school, and improved sanitation, is determined less by need than by their ability to pay.

Finally, the situational analysis demonstrates the risk that a cycle of violence could develop in Zimbabwe in the near future. This violence is manifest across the entire spectrum from poorly regulated corporal punishment, to increased reports of child abuse, through to sexual and gender-based as well as politically-motivated violence.
Conclusion and Recommendations

The advent of the Inclusive Government and the current period of relative economic stability may represent the best opportunity that Zimbabwe has had or will have for many years to break this cycle of deterioration in the situation of women’s and children’s rights. Already during 2009 and 2010, major progress has been made in stabilizing the water and sanitation and health sectors, improving food security, and beginning to rebuild the education sector as well as revitalize key social protection measures such as BEAM. It is critical that this time-limited window of opportunity is fully exploited to institute the following:

1) Protect the recent gains made on the supply side (including in urban water, essential medicines, availability of learning materials), by ensuring that basic social services continue to be delivered through either humanitarian or transitional aid or through government expenditure directly.

2) Expand demand-side programmes aimed at supporting access for the poorest into a comprehensive child-centred social protection strategy that includes: abolition of user fees for pregnant women and children under 5 in the health sector; expansion and improvement of BEAM in education; developing pro-poor water tariffs in water; and initiating a national social cash transfer programme targeting the poorest, labour constrained households. Newer generation social mobilisation and behaviour change programmes, particularly focused on HIV prevention among young women, and that engage all religious groups including the important Apostolic communities, will also fall into this category.

3) Support policy reform in critical ministries to ensure that Zimbabwe benefits fully from global developments over the past decade and best practice is integrated into new policies and strategies. The new child survival strategy of the MoHCW with its focus on the newborn is an excellent recent example. Discussions on initiating new community-led sanitation approaches present an important opportunity as do the plans to implement pre-trial diversion for children in the justice sector.

4) Support the relevant ministries in the Inclusive Government to advocate for increased domestic resources for health, education, water and sanitation, social protection and child protection in line with MTP priorities. The recent efforts to develop investment cases in health and education are excellent examples of such work that provide good models for other sectors.

5) Encourage donors to continue to find innovative transitional financing mechanisms that assist women and children in line with MTP priorities but also help rebuild national capacity in critical areas. The recent efforts to establish an Education Transition Fund, the redesign of the Programme of Support for OVC, and plans for a Maternal and Child Survival Fund are excellent examples of this funding approach, while the capacity audit of the social welfare department of the MOLSS will provide a good example of systematic capacity assessment.

6) Develop ways to break the cycle of violence and protect women and children. Such programmes will span the spectrum from policy work, such as ensuring Zimbabwe ratifies the optional protocols of the CRC on the sale of children, child pornography and involvement of children in armed conflict, to operational research such as the planned national study on violence against children, to supporting the MoESAC in helping to re-train and supervise teachers in order to guard against child sexual abuse and advocate for a ban on corporal punishment.

7) Finally, it will be imperative to continue to find ways to ensure women and children participate directly in critical programmes that affect them. The recent example of the COPAC consultations on the constitution with children should be instructive in this regard. The youth, particularly out of school youth, must be consulted and remain a priority for academic and vocational ‘second chance’ educational opportunities.
8 Bibliography

Adebanjo D. Gender Budgeting: Case Study of the Zimbabwe Experience, Open Society Initiative for Southern Africa


African Development Bank (2007) Rapid Assessment of Water and Sanitation Situation in Zimbabwe

Africa Union, Plan of Action Towards an Africa Fit for Children

Africa UNITE (2010), Campaign Workplan on Violence Against Women

Akwara P, Noubary B et al., Who is the vulnerable child? Using survey data to identify children at risk in the era of HIV and AIDS. AIDS Care, 22:9, 1066-1085


Arrehag L. et al., 'New variant famine' revisited: chronic vulnerability in rural Africa


Bijlmakers et al. (1998), Socioeconomic Stress, Health and Child Nutritional Status in Zimbabwe at a Time of Economic Structural Adjustment - A three-year longitudinal study: Research Report No 105, Nordiska Afrikainstitutet, Uppsala


Birdthistle I. et al (2010), Child sexual abuse and links to HIV and orphanhood in urban Zimbabwe, Journal of Epidemiology and Community Health


Block et al., 'Macro Shocks and Micro(scopic) Outcomes: Child Nutrition During Indonesia's Crisis', Economy and Human Biology, 2003


Central Statistics Office (2009), ICDS 2008

Central Statistics Office (2009), Multiple Indicator Monitoring Survey, Preliminary Report


Chakanyuka S, Chung F, Stevenson (2009) The Rapid Assessment of Primary and Secondary Schools, conducted by the National Education Advisory Board


Chikanda A (2004), Skilled health professionals’ migration and its impact on health delivery in Zimbabwe: Centre on Migration, Policy and Society Working Paper No. 4, University of Oxford

Childline Zimbabwe and CCORE (2010), Sexual Abuse Report, December 31st 2008 - January 1st 2010

Chimhowu A. (2009), Moving Forward in Zimbabwe: Reducing Poverty and Promoting Productivity, The University of Manchester Brooks World Poverty Institute


Cowan F. et al (2008), The Regai Dzive Shiri Project: a cluster randomised controlled trial to determine the effectiveness of a multi-component community-based HIV prevention intervention for rural youth in Zimbabwe - study design and baseline results, Tropical Medicine and International Health 13:10 1235-1244


de Waal A, Evidence for the 'New Variant Famine' Hypothesis in Africa, Justice Africa


Dolata S and Ross K (2010), How Effective are HIV/AIDS Prevention Education Programmes? IIEP Newsletter Vol. XXVIII, No. 3 (September, 2010)

Drimie S. and Casale M. (2009), Multiple stressors in Southern Africa: the link between HIV/AIDS, food insecurity, poverty and children's vulnerability now and in the future, AIDS Care 21:1, 28-33

Economist Intelligence Unit, Country Report: Zimbabwe, 2009

EQUINET (2008), Equity Watch: Assessing progress towards equity in health, Zimbabwe

European Commission (2008), Study on access to health care services in Zimbabwe

FAO (2008), Guidelines for measuring household and individual Dietary Diversity, Italy, Rome

FAO and UNAIDS (2003), Addressing the impact of HIV/AIDS on ministries of agriculture: focus on eastern and southern Africa

FAO and UNICEF (2007), Understanding the Livelihoods of Children with Disabilities and their Families in Zimbabwe

FAO and WFP (2009), Crop and Food Security Assessment Mission to Zimbabwe, Special Report


Futures Group Internation, Research Triangle Institute, Center for Development and Population Activities (1999), The Economic Impact of AIDS in Zimbabwe

Food and Nutrition Council (2010), Strengthening Food and Nutrition Security Analysis in Zimbabwe

Food and Nutrition Council (2009), Report on Consultative Meeting with the Task
Bibliography

Force for Food and Nutrition Policy, Towards a Food and Nutrition Policy

Food and Nutrition Council (2009), Update on Food and Nutrition Situation and the Existing Institutional Arrangements (powerpoint presentation)


Girl Child Network, Gravity of Girl Child Sexual Abuse in Zimbabwe, "Towards Creating a Culture of Prevention"

Government of Zimbabwe (2009), Aid Coordination Policy, Office of the Prime Minister

Government of Zimbabwe (2009), 100-Day Plan (29 April to 6 August), Getting Zimbabwe Working Again


Government of Zimbabwe (2010), Guidelines to Mainstream Gender in Expenditure Proposals and Performance Agreements for 2010

Government of Zimbabwe (2010), Medium Term Plan (Draft)

Government of Zimbabwe (2010), Mid-Term Fiscal Policy Statement, presented by the Minister of Finance

Government of Zimbabwe (2009), National Nutrition Health Survey

Government of Zimbabwe (2009), Progress of Zimbabwe in terms of the Solemn Declaration on Gender Equality in Africa 2004-2008

Government of Zimbabwe (2009), Second Periodic Report of the Republic of Zimbabwe to the Committee on the Rights of the Child, (not yet approved and published)

Government of Zimbabwe (2009), Small Holder Farmer Input Support Programme for Food Security 2009/10 Summer Cropping Season

Government of Zimbabwe (2009), Short-Term Emergency Recovery Programme (STERP), Getting Zimbabwe Moving Again

Government of Zimbabwe (2010), Three Year Macro-Economic Policy and Budget Framework


Government of Zimbabwe (2010), World Fit for Children, End-Decade Report, Zimbabwe 2001-2010


Government of Zimbabwe, Education Act, 2004 Amendment

Government of Zimbabwe (2003), Poverty Assessment Study Survey

Government of Zimbabwe (1999), Report of the Presidential Commission of Inquiry into Education Training, also known as the 'Nziramasanga Report'.


Great Minds Investments Private Limited (2010), Research Support for Data Collection to Measure Outcome of the NAP for OVC Programme Interventions under the Programme of Support


Gregson S. et al (2005), HIV infection and reproductive health in teenage women orphaned and made vulnerable by AIDS in Zimbabwe, AIDS Care 17:7, 785-794


Hanke S. (2008), Zimbabwe from Hyperinflation to Growth, Cato Institute No.6


HelpAge International, The impact of HIV/AIDS on older people


Huisman H (2005), Contextualising Chronic exclusion: Female headed households in Semi Arid Zimbabwe, Royal Dutch Geographical Society, Volume 96 No. 3 pp 253 - 263


IMF (2010), Zimbabwe: Challenges and Policy Options after Hyperinflation

IMF (2010), Zimbabwe: 2010 Article IV Consultation - Staff Report; Staff
Bibliography

Supplement; Public Information Notice on the Executive Board Discussion; and Statement by the Executive Director for Zimbabwe (Country Report No. 10/186)

IMF (2009), Zimbabwe: 2009 Article IV Consultation - Staff Report; Public Information Notice on the Executive Board Discussion; and Statement by the Executive Director for Zimbabwe (Country Report No. 09/139)

IMF (2005), Zimbabwe: Selected Issues and Statistical Appendix (Country Report No. 05/359)

ILO (2010), Worst Forms of Child Labour, Zimbabwe Report (Draft)


IOM (2010), Policy Discussion Paper on Child Trafficking in Zimbabwe

Jenkins et al. (2010), Exposure to road shows is associated with more knowledge and positive beliefs, attitudes and social norms regarding exclusive breastfeeding among men and other community members in rural Zimbabwe. Submitted to Journal of Nutrition

J. F. Kapnek Trust (2005), Children’s Rehabilitation Unit, Data Analysis and Review January 1986 - May 2005

Jimat Development Consultants (2010), Programme of Support for the National Action plan for Orphans and Other Vulnerable Children Outcome Assessment Final Report


Joint Learning Initiative on Children and HIV/AIDS (JLICA) (2008), Home truths. Facing the facts on children, AIDS, and poverty


Justice for Children Trust (2008), Statistics and Analysis which were received by the Legal Aid Department in 2007

Kairiza T. (2009), Unbundling Zimbabwe's journey to hyperinflation and official dollarization, National Graduate Institute for Policy Studies


Kinsey W. (2010), Poverty Dynamics in Rural Zimbabwe: The 30 Years (Lost) 'War against Poverty', The University of Manchester Brooks World Poverty Institute


Lanata and Black (2001), Diarrheal Diseases, in Nutrition and Disease in Developing Countries, Humana Press

A Situation Analysis on the Status of Women's and Children's Rights in Zimbabwe, 2005 - 2010: A call for Reducing Disparities and Improving Equity
Bibliography


Loewenson R et al. (2009), Health where it matters most: An assessment of Primary Health Care in Zimbabwe March 2009, Report of a Community-Based Assessment, Training and Research Support Centre and Community Working Group on Health

Lyons M. The Impact of HIV and AIDS on Children, Families and Communities: Risks and Realities of Childhood during the HIV Epidemic, Issues Paper 30

Maastricht Graduate School of Governance (2008), Measuring Child Poverty and Well-Being: a literature review

Mapfumo P (2009), Integrating sustainable soil fertility management innovations in staple cereal system and other value chains to enhance livelihoods and environmental systems in Africa, Soil fertility Consortium for Southern Africa, Harare, Zimbabwe

Machingura F (2010), Strengthening Community Health Systems for HIV Treatment, Support and Care, Kariba District, Zimbabwe, TARSC

Mbuya et al. (2010), Biological, Social, and Behavioral Determinants of Low Birth Weight and Stunting Among Infants and Young Children in Zimbabwe

McGregor J. (2006), Professionals Relocating: Zimbabwean Nurses and Teachers negotiating Work and Family in Britain, University of Reading Geographical Paper No.178


Miller C. (2007), Zimbabwe Child & Family Vulnerability Analysis

Ministry of Education, Sport, Arts and Culture (2010), Back on Track: Reviving Pre-Tertiary Education in Zimbabwe, A Draft Interim Strategy prepared by MOESAC for Discussion with Development Partners (powerpoint presentation)

Ministries of Education, Sport, Arts and Culture and Higher and Tertiary Education (2010), Cost and Financing of the Education Sector in Zimbabwe


Ministry of Education, Sport, Arts and Culture, Proposed Basic Education Policy 2006-2010


Ministry of Finance, '2010 Mid-Year Fiscal Policy Review', presented by the Minister of Finance, 14 July 2010

MoHCW, National Child Survival Strategy for Zimbabwe 2010-2015, June 2010


Ministry of Health and Child Welfare (2007), Adolescent Sexual and Reproductive Health: An Analysis of the 2005 to 2006 Zimbabwe Demographic and Health Survey Data


Ministry of Health and Child Welfare, the Food and Nutrition Council and UNICEF (2008), Combined Micronutrient and Nutrition Surveillance Survey

Ministry of Health and Child Welfare (2009), Getting the Zimbabwe Health Care System Moving Again, Health Action Plan for the First 100 Days March - June 2009


Ministry of Health and Child Welfare (2010), The Health Sector Investment Case 2010 - 2012), Accelerating progress towards MDGs


Ministry of Health and Child Welfare (2008), Why has HIV prevalence declined in Zimbabwe? Stakeholder Consultation on Findings from Epidemiological Modelling and Qualitative Research


Ministry of Labour and Social Services and UNICEF (2010), Programme of


Ministry of Women Affairs, Gender and Community Development (2005), National Gender Based Violence Strategy Document and Action Plan

Ministry of Women Affairs, Gender and Community Development (2010), National Gender Based Violence Strategy Document and Action Plan


Munjanja S, Maternal and Perinatal Mortality Study 2007, MoHCW

National AIDS Council/UNAIDS, Modes of Transmission Prevention Review Report, August 2010

Munro L. (2003), A Social Safety Net for the Chronically Poor? Zimbabwe’s Public Assistance in the 1990s (Draft)


National AIDS Council, Zimbabwe National HIV and AIDS Strategic Plan 2006-2010
National AIDS Council (2009), Zimbabwe National HIV and AIDS Strategic Plan, Mid-term Term Report

National AIDS Council/Technical Support Group (2005), Comprehensive review of behaviour change for preventing HIV transmission through sexual transmission in Zimbabwe

National Education Advisory Board (2010), Special Needs Education Research Study

National Education Advisory Board, The Role of Legislation and Policy Framework in Education


Nhundu T and Shumba A (2001), The nature and frequency of reported cases of teacher perpetrated child sexual abuse in rural primary schools in Zimbabwe, Child Abuse and Neglect 25, 1517-1534


O'Mally B (2010), Education Under Attack, UNESCO

Oxford Policy Management and Jimat Development Consultants (2010), Institutional Capacity Assessment - Department of Social Services, Inception Report

Pascoe S. et al (2010), Increased risk of HIV-infection among school-attending orphans in rural Zimbabwe, AIDS Care 22:2, 206-220

Plan Zimbabwe (2009), Research Report on Child Abuse in Schools: A Baseline Study for the "Learn Without Fear Campaign"


Powell G. et al (2005), Children in Residential Care, the Zimbabwean Experience (Report and powerpoint presentation)

The Republic of Zimbabwe (2006), 7th, 8th, 9th and 10th Combined Report under the African Charter on Human and People's Rights

The Republic of Zimbabwe (2009), Combined Report in terms of the Convention on the Elimination of all forms of Discrimination Against Women (CEDAW)


Rusakaniko S. et al., Trends in the burden of orphans and vulnerable children in
Zimbabwe: evidence from national household surveys, 1994 - 2005, Ministry of Health, CDC Zimbabwe, CSO Zimbabwe, DFID and USAID

Sambisa W. et al (2010), AIDS stigma as an obstacle to uptake of HIV testing: evidence from a Zimbabwean national population-based survey, AIDS Care 22:2, 170-186

Sanders D. (1990), Equity in Health: Zimbabwe Nine Years On, Journal of Social Development in Africa 5:1, 5-22

Save the Children Norway/CCORE (2010), Characteristics of "Children on the Move" 2007-2009

Save the Children Norway, Childline, Streets Ahead (2009), The nature and prevalence of violence and sexual abuse among boys living and working on the streets of Harare

SayWhat? (2010), Assessing SRH Programming, Knowledge Levels and Services for Students in Zimbabwe's Tertiary Institutions

Semba and Gray, Human Immunodeficiency Virus Infection, In Nutrition and Health in Developing Countries, Humana Press, 2001


Shumba A. et al., Corporal Punishment in Zimbabwean Schools: Aetiology and Challenges

Sibanda, D. M. Meeting with Permanent Secretary Ministry of Economic Planning and Investment Promotion, 17 August 2010

Sida (2010), The Cost of Gender Based Violence in Zimbabwe: Issues and Policy Options

Sightsavers International, Not on the Guest List: Disabled People and the Millennium Development Goals (MDGs)

Sexual Violence Research Initiative (2009), SVRI Forum 2009 Conference Report

Thabete S. (2009), SADC Gender Barometer Baseline Study, Zimbabwe

Todd C, Ray S, Madzimbamuto F and Sanders D (2009), What is the way forward for health in Zimbabwe? The Lancet Vol 375 (9714): 606-609

Tsanga A et al. (2004), Children and Women's Rights in Zimbabwe Theory and Practice, UNICEF

UNAIDS (2009), Review of the Effectiveness of Promoting HIV Prevention Behaviour Change at Community Level through Behaviour Change Facilitators in Zimbabwe

UNAIDS and WHO (2009), 09 epidemic update
Bibliography

UNDESA (2006), Poverty measurement and gender: Zimbabwe's experience


UNDP (2005), 2003 Poverty Assessment Study Survey Findings (powerpoint presentation)


UNESCO (2010), Education Under Attack


UNFPA and IOM (2008), Sexual and Reproductive Health (SRH) Needs Assessment Among Mobile and Vulnerable Population (MVP) Communities in Zimbabwe Study Report

UNICEF (2010), Adapting a Systems Approach to Child Protection: Key Concepts and Considerations

UNICEF (2009), Child Friendly Schools for Africa, Multi-country Initiative (2010-14)


UNICEF (2010), Child-Sensitive Social Protection in Zimbabwe (Final Draft)

UNICEF (2008), Child Protection Strategy, UNICEF Executive Board annual Session

UNICEF (2009), Education Transition Fund Concept Note

UNICEF (2002), Hope Never Dries Up: Facing the Challenges, A Situation Assessment and Analysis of Children in Zimbabwe, 2002 Update

UNICEF (2010), Narrowing the Gap to Meet the Goals

UNICEF (2010), Progress for Children: Achieving the MDGs with Equity


UNICEF (2007), Supporting the Realization of Children's Rights through a Rights-Based Approach to Legislative Reform


UNICEF (2009), The Situation of Children in Zimbabwe, Global Study on Child Poverty and Disparities (Draft)
UNICEF, Situation Analysis Update of Children: Poverty and Inequality in Focus, 2005

UNICEF (2010), Zimbabwe, Protecting the Child Survivor of Sexual Abuse - the Victim Friendly System


UNICEF, UNFPA & IOM (2009), Joint Gender-Based Violence Field Mission, Zimbabwe

UNFPA (2008), In-Depth Analysis of Childhood Mortality: Findings from an Assessment of Demographic and Health Surveys, Inter-Censal Demographic Surveys and Population Censuses in Zimbabwe

United Nations (2010), Consolidated Appeal


United Nations Inter-agency Group for Child Mortality Estimation, 2010

USAID (2008), Orphans and Vulnerable Children in High HIV-Prevalence Countries in Sub-Saharan Africa, DHS Analytical Studies 15

U.S. Center for Disease Control (2009), Evaluation of WASH Cholera Response to 2008-09 in Zimbabwe (Draft)

U.S. Center for Disease Control (2009), Trip Report: Active Surveillance and Mortality Study, Post-Cholera Outbreak in Zimbabwe


Watts H. et al (2007), Poorer health and nutritional outcomes in orphans and vulnerable young children not explained by greater exposure to extreme poverty in Zimbabwe, Tropical Medicine and International Health 12:5, 584-593

Whiteside A. et al (2003), Through a glass darkly: data and uncertainty in the AIDS debate, Developing World Bioethics, 3:1, 49-76

WHO (2002), Impact of AIDS on Older People in Africa, Zimbabwe Case Study


WHO, UNICEF, ICCIDD, Assessment of IDD and Monitoring their Elimination

Women and Law in Southern Africa Research and Education Trust (2009), Sex, Rights and the Law in a World with AIDS: Gender, HIV/AIDS and the Law in Zimbabwe
Bibliography

Women and Law in Southern Africa Research Trust (1999), Zimbabwe: The Ongoing Struggle for Women’s Legal Rights

World Bank (2010), Country Status Overview Zimbabwe

World Bank (2009), Establishment of a Programmatic Multi-Donor Trust Fund for Zimbabwe

World Bank (2009) Gender-Based Violence, Health and the role of the Health Sector

World Bank (2007), Interim Strategy Note, FY08-09 for the Republic of Zimbabwe


Zimbabwe Association of Doctors for Human Rights, 2009

Zimstat and UNICEF, Multiple Indicator Monitoring Survey (MIMS), 2009


ZimConsult, Human Security in Zimbabwe - Economic meltdown (powerpoint presentation)

Zimbabwe Human Rights NGO Forum (2001), Gender and Constitutional Issues, Special Report 2

Zimbabwe Republic Police (2009), Victim Friendly Unit Annual Report 2009


ZIMVAC, Zimbabwe Urban Areas Food Security and Vulnerability Assessment 2003, 2006 and 2009
Annex 1: Livelihoods and coping strategies of women and children in rural areas

1 Background

Agricultural production has suffered as a result of weak support services, lack of credit, acute shortages of essential inputs, and the impact of HIV. These conditions are exacerbated by poor soil fertility and low water availability. Many rural areas have not recovered from the impact of erratic rainfall, as recurrent droughts make it difficult for people to improve their situation. Regular shocks have wiped out savings and productive assets, increased people’s vulnerability and reduced their productivity. Loss of livestock has resulted in loss of draught power and reduced productivity. With increased frequency of dry spells, women and young girls walk long distances to collect water.

This case study examines the condition of female and male-headed households in rural areas. In 2008, a total of 750 small-holder communal farmers in 25 villages from two provinces were interviewed (270 female-headed and 480 male-headed). It should be noted that the data is geographically-specific and although conditions are most likely quite similar, or worse, in other provinces, generalised conclusions must be derived with caution.

The interviews guided the collection of background information about the sampled households including information on household characteristics, asset ownership, the mix of agricultural enterprises and income sources. It is recognised that the data is cross sectional and hence does not provide insight into changes in livelihood strategies for children and women. As a result, the conclusion and recommendations made from the data analysis may be applicable only to geographic areas involved in the study or other similar locations.

2 Access to social and physical amenities

The data showed differences between women and men’s access to social and physical amenities. Women tended to use more time in accessing social and physical amenities, due to a large proportion of their day (and night) allocated to subsistence activities that provide for the household’s daily food needs and which involve travel.
Most people living in rural areas depend on communal boreholes and wells for drinking water. The mean travelling distance to the nearest source is 4.3 kilometres. During periods of poor rainfall, the distance can be even greater. The mean number of households per water source is estimated at 50. Where the number of households is higher, it is unsurprising to find women and young girls queuing for water. On average, women and young children have to make at least three errands per day to collect water.

The mean distance to the nearest agriculture extension officer is 12 kilometres, a significant barrier that prevents women from attending meetings with extension officers. As a result, women lack knowledge regarding the application of agricultural inputs, growing alternative, more drought resistant crops and conservation farming.

Following the economic crises, the accessibility of financial services was reduced due to the many commercial banks pulling out of small towns. Similarly, many transport providers also withdrew from the rural areas, meaning women had to travel long distances to reach a bank or commercial bus stop.

The most common source of energy is firewood. Traditionally in Zimbabwe, collecting firewood is seen as an activity completed by women and young girls. While the mean travelling distance to firewood is only 1.6 kilometres, deforestation and population growth mean this distance is increased to 5 kilometres in some parts of the country. Lack of transport (scotch carts and draught power), labour and social capital make it difficult for children and women to access such resources outside their immediate village.

In addition to firewood collection women and girls take on the work of tending to vegetable gardens often situated along perennial rivers and small water bodies. The mean travelling distance to the nearest reservoir is 1.5 kilometres. This distance increases during times of drought, which impacts household essential vitamins and protein intake due to shortages of vegetables and fish.

The mean travelling distance to the nearest health service centre is 8.7 kilometres. This distance is usually covered on foot or using an ox-drawn cart and disproportionately affects health service access for vulnerable groups such as infants, the elderly and pregnant women. The distance to health services, for example, is a contributing factor to the 39 per cent of pregnant women who do not deliver their child in an institution. The distance also presents a barrier to mothers taking infants to clinics for post-natal care.

Following Zimbabwe's independence in 1980, the Government increased the number of schools located in rural areas. Consequently, physical access to education in rural areas is generally not an impediment to school enrolment. The mean travelling distance to the nearest primary school is three kilometres.

### Table 1: Mean, Minimum and Maximum distances to social and physical amenities

<table>
<thead>
<tr>
<th>Access to</th>
<th>Maximum (km)</th>
<th>Minimum (km)</th>
<th>Mean distances (km)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Borehole/wells</td>
<td>7.0</td>
<td>1.0</td>
<td>4.30</td>
</tr>
<tr>
<td>Newspaper</td>
<td>60</td>
<td>1.5</td>
<td>32.64</td>
</tr>
<tr>
<td>Agritex Officer</td>
<td>36</td>
<td>1.5</td>
<td>12.09</td>
</tr>
<tr>
<td>Bank</td>
<td>67</td>
<td>1.5</td>
<td>31.00</td>
</tr>
<tr>
<td>Firewood</td>
<td>2.0</td>
<td>1.0</td>
<td>1.63</td>
</tr>
<tr>
<td>Water</td>
<td>2.0</td>
<td>0.1</td>
<td>1.52</td>
</tr>
<tr>
<td>Churches</td>
<td>10</td>
<td>1.0</td>
<td>5.02</td>
</tr>
<tr>
<td>Health services</td>
<td>25</td>
<td>2.5</td>
<td>8.67</td>
</tr>
<tr>
<td>Bus stop</td>
<td>11</td>
<td>1.5</td>
<td>6.65</td>
</tr>
<tr>
<td>Schools</td>
<td>5.0</td>
<td>1.5</td>
<td>2.95</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Average distances (km)</th>
<th>Borehole/wells</th>
<th>Newspaper</th>
<th>Agritex Officer</th>
<th>Bank</th>
<th>Firewood</th>
<th>Water</th>
<th>Churches</th>
<th>Health services</th>
<th>Bus stop</th>
<th>Schools</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum distances (km)</td>
<td>7.0</td>
<td>60</td>
<td>36</td>
<td>67</td>
<td>2.0</td>
<td>2.0</td>
<td>10</td>
<td>25</td>
<td>11</td>
<td>5.0</td>
</tr>
<tr>
<td>Minimum distances (km)</td>
<td>1.0</td>
<td>1.5</td>
<td>1.5</td>
<td>1.5</td>
<td>1.0</td>
<td>0.1</td>
<td>1.0</td>
<td>2.5</td>
<td>1.5</td>
<td>1.5</td>
</tr>
</tbody>
</table>

### Footnotes


3 Socio-economic status of heads of household

Table 2: Socio-economic characteristics of household heads

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Female-headed Households (%)</th>
<th>Male-headed Households (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>55.3</td>
<td>52.2</td>
</tr>
<tr>
<td>Farming experience</td>
<td>27.8</td>
<td>19.4</td>
</tr>
<tr>
<td>Living with the aged</td>
<td>0.5</td>
<td>0.6</td>
</tr>
<tr>
<td>Dependence ratio</td>
<td>2.5</td>
<td>2.3</td>
</tr>
<tr>
<td>Household size</td>
<td>5.8</td>
<td>5.9</td>
</tr>
<tr>
<td>Land owned</td>
<td>7.5</td>
<td>8.5</td>
</tr>
<tr>
<td>Land under cultivation</td>
<td>4.3</td>
<td>5.8</td>
</tr>
<tr>
<td>2007/8</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The average age of female-headed households is significantly higher than that of men, with most aged 16-59 years. This group also includes 51 per cent of the chronically ill, who are likely to have a negative impact on household livelihoods.228

Interestingly, women’s farming experience is significantly higher than that of men. This difference is most likely due to men seeking formal employment while women and children remain in the rural home to farm and care for livestock.

The mean number of female-headed households living with the elderly and dependent children is not significantly different from that of male-headed households. HIV/AIDS-related mortality has left many children under the care of grandparents.229 In commercial farming areas, orphaned children have become child-headed households and are forced to join the labour force as child labourers in an effort to provide for the rest of the family.230 In rural areas however, relatives, commonly grandparents, absorb the orphans into their households. By necessity children participate in farming, caring for livestock and income generation in order to contribute to school fees and other expenditures.

There is no significant difference between the land sizes owned by female-headed and male-headed households. However, the majority of female-headed households reported lower cultivation rates. As indicated further in this chapter, the lower cultivation rates is a result of insufficient draught power, insufficient money to purchase inputs, poor quality land and insufficient labour; Only 44 per cent of female-headed households can hire labour, compared to 56 per cent of male-headed households.

4 Levels of human capital

The configuration of the datasets makes it difficult to analyse the structure of the household or educational levels of household members other than the household head. As such, in this analysis, education is used as a proxy for human capital.

The majority of all heads of household possessed only

Figure 1: Education levels attained by head of household (by percentage) (n = 750)

Table 2: Socio-economic characteristics of household heads

FOOTNOTES

Annex

low levels of formal education, although men have more secondary education than women (See Figure 2). The lack of education could be explained by the age of the household heads; most of the respondents were educated pre-independence when education opportunities were less available. Low levels of education have been associated with lack of access to credit, limited understandings of legal rights to education and the various support mechanisms in place. The general low level of education among female-headed household is cause for concern given the relationship between low education of female-headed households and high risk of underachievement by their children.231

The factors that create a female-headed household tend to define the social and economic status of that household. For example, if a woman is widowed the ‘family court’ determines whether she will be allowed to remain living in the homestead of her late husband. If the widow is allowed to continue to use the land, in most cases it does not imply full control. If there is a male child in the household, he inherits the land use rights of his deceased father. In the case of a divorce, most women lose rights to the property and are forced to migrate.

As shown in Figure 3: Marital status of household heads (percentage), most female heads of household are widowed (80 per cent), while 18 per cent are divorced. These figures contrast dramatically with male heads, most of whom are monogamously married (74 per cent) or single (12 per cent).

FOOTNOTES

5 Access to farming implements and inputs

The type of productive assets owned by a household are an important component of the household's productive technology. The distribution of such assets among the household determines the inter-temporal distribution of income and predicts the future trajectory of the household's standard of living. Besides ownership of a house, a draught animal, plough, hoes and scotch cart are the minimum bundle that delineates the poor from the well-off and determines the household's future trajectory.232

Male-headed households are more likely to own scotch carts, animal draught power and ploughs. Without these assets, women face extreme difficulty in cultivating land.

6 Access and Use of Inputs by Male and Female

A high proportion of people in communal areas have access to improved seed varieties and pesticides (over 90 per cent), with no significant difference between female and male headed households. Both men and women do not have access to fertiliser, which results in low crop productivity. Without fertilisers, yields are reported to have fallen by three quarters, driving many households into a downward spiral of increased food insecurity, income decline and a subsequent inability to purchase next season's necessary agricultural inputs.

7 Ownership of Livestock

Without secure savings schemes, households wishing to save for school fees and other expenses do so in the form of livestock. Women are more likely to own poultry and significantly less likely to own cattle than men. Often women lose cattle to in-laws following a husband's death, or in the case of children live stock are passed on when their parents die.

Kundai’s Story

Kundai, 32, became pregnant by her former employer and gave birth to boy. One of Kundai’s sisters died of HIV, leaving a son in Kundai’s custody. Another of Kundai’s sisters also left her a son when she re-married. Kundai married and had one child of her own. Her husband left for South Africa during the economic crisis of 2008 and never came back. Kundai’s in-laws later suggested she return to her parents’ home. As she and her husband had not accumulated property, she left her in-laws without any productive assets. Currently, Kundai is staying with four dependent children on her late parents' homestead. Her two brothers (both married) have inherited their late parents’ property and allocated Kundai only small sandy pieces of land that they and their wives do not want. Without draft power she uses a hoe to plough the land and in most cases cultivates only a very small area.

Tendai’s Story

Tendai, 21, is an only child who was orphaned at the age of 11. When her father died, his relatives took away most of the household property. A year later, her mother also passed away and the remaining assets were taken by her mother's relatives. Tendai lost all the livestock and assets acquired by her parents. She chose to remain at her parents' home, rather than staying with relatives. The 'family court' allowed her to continue cultivating her late parents' land and she worked on nearby farms during weekends and holidays in order to raise money for food and school fees. She later dropped out of school and went to live with an aunt. At the age of 15 she became pregnant by her uncle and was thrown out of the home. She gave birth to a boy who was then claimed and taken by her aunt and uncle. She later had two more children from different men. Her youngest child is always sick, probably due to HIV/AIDS. Tendai eventually resorted to commercial sex work.

FOOTNOTES

8 Access to credit

Farmers are highly dependent on savings made from produce sales in the previous season. Few people in rural areas have savings with the bank, but the proportion of men with savings (30 per cent) is significantly greater than that of women (23 per cent). Therefore women have to borrow money to finance farming and meet other family needs. Only 1.5 per cent of female-headed households and 13 per cent of male-headed households had access to formal sector agriculture finance in the 2007/8 agriculture season. Only 3 per cent of female household heads and 1.5 per cent of male heads of households obtained a loan from moneylenders. Government administered rural credit schemes were offered to only 5 per cent of the female-headed households and 7 per cent of the male-headed households and suffered from extremely low repayments rates. Kinship networks are clearly important for rural smallholders with 40 per cent of female-headed and 31 per cent of male-headed households obtaining credit from relatives.

9 Agricultural production and sources of income

Approximately 40 per cent of female-headed households and 30 per cent of male-headed households relied on remittances. The sale of crops provided income for over 56 per cent of female-headed households and 57 per cent of the male-headed households, but contributed to overall household income by only 25 and 20 per cent, respectively. A large proportion of women derived income from casual labour (18 per cent) and regular employment (18 per cent).

10 Food security coping strategies

Three distinct measures were used to measure household food security. These measures were:

a) Food availability - the sufficient quantities of appropriate, necessary types of food from domestic production and other sources consistently available to individuals;

b) Food access - individuals have adequate incomes or other resources to purchase or barter to obtain levels of appropriate food needed to maintain consumption of an adequate diet/nutrition level;

c) Number of months of food self provisions - used as a proxy for a crop yield and value of production indicator. This measure is based on the assumption that production was entirely for subsistence and covers grain, legumes and tubers.

10.1 Dietary diversity and food availability

Dietary diversity is a qualitative measure of food consumption that reflects households’ access to a wide variety of foods and is a proxy measure of the nutrient adequacy of the diet of each household. More female-headed households (36 per cent) are in the low dietary diversity group. This proportion was higher than male-headed households (30 per cent). Those in the low dietary diversity group are considered to be food insecure and survive on cereal (mostly sadza, made of maize) and vegetables without oil.

The majority of households fall in the medium dietary diversity group; 54 per cent of female-headed households and 58 per cent of male-headed households. They consume cereal, green leafy

FOOTNOTES

vegetables and oil. Only 9 per cent of female-headed household and 12 per cent of male-headed households are in the high dietary diversity group. This group is associated with high level of caloric availability.

Male-headed households tend to have more access to legumes and nuts, meat, milk and oils than female-headed households. However, all households survive on less than two meals a day. Despite remittances obtained by women, women still suffer food inadequacies suggesting that either the remittance money is not enough or it is used to meet other pressing family needs such as school fees, to hire draught power, or to pay health bills.

10.2 Coping strategies

Households face difficulties in recovering from shocks that operate at an aggregate level, affecting the entire community, country and region, as risks cannot be shared.234 A household's initial conditions (household assets, household characteristics, including dependence ratio and educational status of household members) influence the household’s vulnerability to shocks and the forms of available coping strategies. Female-headed households are less able to deal with shocks than male-headed ones, as are households headed by orphans, the elderly and the chronically ill. These coping strategies are outlined by gender in Figure 5: Coping strategies by gender of household head.

The majority of female-headed households adopted forms of coping strategies that may support short-term survival but undermine wellbeing in the medium to long term. The adverse coping strategies employed included mortgaging crucial assets and reduction of food consumption with potential irreversible harmful affects. The most common coping strategy employed was reducing the number of meals, modifying cooking methods, substituting commonly bought food with cheaper alternatives, children eating less and borrowing from neighbours.

FOOTNOTES

234 Dercon,S., ’Income risk, coping strategies and safety nets,’ Working Paper, Centre for the Study of African Economies, Oxford University, 2004

Maria’s Story

Maria, a 13 year old orphan, lives with her 11 year old sister and two brothers, aged nine and seven. Her parents died of AIDS related causes two years ago. Maria’s parents left some basic household assets such as a plough, an ox-cart and a few cattle. However, the four children are too young and inexperienced to use animal draught power and the plough. During the rainy seasons the children rent out the ox-cart, draft power and plough. Sometimes, they are underpaid. At times Maria bartersthe use of the draught power and ox-cart for labour to work in their field. To raise school fees for her and her siblings, she sells crops and hires out the ox-cart. Maria cannot afford fertilisers and pesticides and does not produce a surplus. The children quickly run out of food. When this happens, her brother and sister sometimes eat at neighbours' homes.
11 Level of social integration

Membership in a marketing group reduces the cost of getting products to the markets and improves the bargaining power of farmers. This collective marketing reduces transaction costs and enables smallholders to access services that would not be provided by the private sector or government. Membership provides a platform for sharing ideas and accessing information on commodity prices. Membership in these groups was not significantly different between female and male-headed households (24 per cent).

Social capital allows households to have access to resources and services that would not otherwise be readily available. It promotes network-based relations that are important in facilitating in-kind assistance for the elderly or poor relatives, those with limited labour or draught power and thus reduces vulnerability. Female-headed households have a significantly lower social capital index than male-headed ones. Death of a husband usually negatively affects the family’s social relationships. Women are therefore less likely to benefit from reciprocity and free provision of labour; benefits that can often at least partially address labour constraints and reduce the impact of shocks.

12 Conclusions and recommendations

This study suggests female-headed households cultivate less land, produce fewer crops and own less livestock than male-headed households. They are also disadvantaged in agricultural production and food security, access to land and water, access to equal opportunities in income generation, access to credit, and to education.

Land is considered the most fundamental resource to a rural household’s living condition and economic empowerment. However, women do not have equitable access to this valuable resource. Women’s rights to land are not protected or realised, and customary laws and inheritance practices often impede these rights. Women living in rural areas have limited access to farmland through their male relatives. Further, women often do not have marriage certificates or other legal documents to protect their rights over land and other assets after a husband’s death or divorce. In situations where women buy land or acquire it through the Government resettlement programme, they are often disadvantaged due to lack of capital and access to farm equipment, and farm management knowledge.

The overarching objective of national responses to the livelihoods and coping strategies currently employed by women and children in rural areas should aim at promoting equal opportunities for both sexes; this includes equal opportunities to access food and resources such as capital, technology, agriculture and rural development services, as well as to employment opportunities and participation in decision-making processes.

Improving agricultural productivity of women: Agricultural extension can play an active role by reorienting programs towards the needs of female farmers by promoting labour-saving technologies and low-input agriculture. Direct provision of inputs such as seeds and fertiliser for women will help increase their returns in agricultural production and help improve livelihood security of their families.

Strengthening and protecting the rights of women to land and property: Reforms to the legal framework that guides land ownership is needed to ensure women’s rights are protected and gender parity is promoted. Once these legal instruments are in place, they need to be supported by an efficient law enforcement system and by legal rights awareness campaigns that sensitize and educate the public about gender sensitive land and property laws. Engagement with traditional leadership will be necessary to resolve discrepancies between women’s property rights and discriminatory provisions in customary law.

Ease the domestic labour burdens: Technological development should focus on relieving the burdens of the multifaceted work currently shouldered by rural women in the house, agricultural production, natural resource management, and care giving. For example, improving the household’s access to water and efficient energy sources would help improve the economic opportunities and quality of life. Improved access to basic services in rural communities such as closer water points, improved water-harvesting techniques, more efficient stoves and other affordable household technologies would also help alleviate the burdens on households.
Strengthening informal strategies to improve women’s social capital: There is need also to facilitate the re-emergence of informal and traditional schemes that support the social capital and network support mechanisms for women such as labour-sharing clubs, women-only mutual-aid societies, benevolent groups in churches, draught power clubs, rotating and savings club, cooperatives and women’s market groups.

Economic empowerment of women: For greater economic empowerment, women require more equitable access to credit and income generating livelihoods. Programs that support greater income-generation for women could include support for micro-enterprises, micro-credit schemes, training and improving women's market access.

Assistance to orphans and elderly women: Provision of adequate support and care for orphans and the elderly through community-based interventions remains one of the most important strategies in mitigating the impacts of the HIV epidemic. Vulnerable groups may require support such as free health care, supplemental food, and assistance with school fees.